

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 2 FilmG212 3-28-57 et

2185

CERTIFICATE OF DEATH

02457

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Maryland</u> COUNTY <u>Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jessup 13X22</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>✓</u>	
CITY OR TOWN <u>GLEN BURNIE</u>		LENGTH OF STAY (In this place)		STREET ADDRESS <u>Box 29</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONV. HOME</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>WILBUR</u> (Middle) <u>ALLEN</u> (Last)				(Month) <u>Mar</u> (Day) <u>8</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Allen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Dorothy Brown Jessup, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerotic heart disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Urinary tract infection</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 1, 1956</u> , to <u>Mar 8, 1957</u> , that I last saw the deceased alive on <u>Feb 26, 1957</u> , and that death occurred at <u>7:10 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Joseph A. ...</u>				DATE SIGNED <u>3-8-57</u>			
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar 15 1957</u>		NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgely Selby</u>		ADDRESS <u>Laurel, Md</u>	

MAR 15 1957

CERTIFICATE OF DEATH

Reg. Cert. No.

1. FULL NAME OF DECEASED

2. SEX
3. AGE
4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF COURT

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CORONER

23. SIGNATURE OF JURY

24. SIGNATURE OF COURT

25. SIGNATURE OF JUDGE

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CORONER

28. SIGNATURE OF JURY

29. SIGNATURE OF COURT

30. SIGNATURE OF JUDGE

NOTED

BUREAU V. S.

MAR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02458

2444

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Round Bay Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hugh</u> Middle <u>Auld Jr</u> Last <u>Auld Jr</u>				4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 8, 1898</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>59</u> Days <u>59</u> Hours <u>59</u> Min. <u>59</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile Bus</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Hugh Auld Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Woods</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-01-1836</u>		17. INFORMANT <u>Wife</u> Address <u>Lois Auld Round Bay Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial INFarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>3-14-57</u> , 19____, and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.				DATE SIGNED <u>md. 3-15-57</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>				ADDRESS (Street, city or town, state) <u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Fickner & Sons - Baltimore</u>				ADDRESS <u>Md.</u>			
24a. REC'D BY REGISTRAR <u>3/15/57</u>				24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2487 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02459
25

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pumphrey</u> c. LENGTH OF STAY IN 1b <u>14 y.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5930 Bellegrove Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Roberstson Avery</u>				4. DATE OF DEATH Month Day Year <u>March 23rd.</u> 19 <u>57</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>Dol.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/11/05</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed in selling ice.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gastonia, Georgia.</u>				11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Avery</u>						14. MOTHER'S MAIDEN NAME <u>Mary Bartlow</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-10-6920</u>				17. INFORMANT Address <u>Mrs. Helen Avery, (wife).</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> </div> </div>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>						DATE SIGNED <u>3/23/57</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>				22d. LOCATION (City, town, or county) (State) <u>A.A.Co., Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaiah L. Brown and Son, 108. W. Montgomery</u>						24a. REC'D BY REGISTRAR <u>MAR 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Ada Whitson</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form No. 100

RECEIVED
MAR 28 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02460

2445 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 117 Monticello Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MARY A BASIL				4. DATE OF DEATH Month Day Year 3 16 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 30, 1891	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William J. Flood				14. MOTHER'S MAIDEN NAME Mary A. Ruthard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-30-4844B		17. INFORMANT Address Charles F. Basil Husband same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary edema DUE TO Heart failure - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery, widely DUE TO (c) 1 year							INTERVAL BETWEEN ONSET AND DEATH 2 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 56 to 3/16/57 that I last saw the deceased alive on 3/16/57 and that death occurred at 6:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stuart M. Christilf Jr M.D.				ADDRESS (Street, city or town, state) 69 Franklin DATE SIGNED 3/17/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-20-57		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR MAR 20 1957		24b. REGISTRAR'S SIGNATURE Am. J. French	

BUREAU V. 5

MAR 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD		1957	
CERTIFICATE OF DEATH		1957	
Name of Deceased: Anna Arnold		Sex: Female	
Age: 71		Date of Birth: June 2, 1886	
Place of Birth: Germany		Race: White	
Usual Residence: 119 Hamilton Ave.		Date of Death: March 18, 1957	
Cause of Death: Stroke		Place of Death: Home	
Physician: Dr. J. J. Jones		Hospital: None	
Burial Place: St. John's Cemetery		Date of Burial: March 20, 1957	
Name of Informant: John Arnold		Relationship: Wife	
Signature of Informant: <i>[Signature]</i>		Signature of Physician: <i>[Signature]</i>	
Date of Report: March 20, 1957		Date of Death: March 18, 1957	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02461

2488 CERTIFICATE OF DEATH

Item 7 FilmG212 3-26-57 et

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>ANNE ARUNDEL</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GLEN BURNIE</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto. 3V01.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MAYOR CONV. HOME</u>		STREET ADDRESS <u>348 Camel St.</u>	(If rural give location)
3. NAME OF DECEASED (Type or Print) <u>NETTIE</u> (First) <u>BELL</u> (Middle) <u></u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 10 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 15, 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>56</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Wynn</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Martend Massey 208 Carrollton Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Congestive heart failure</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic arthritis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>117 9752</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 9:30 A.M., from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>102 Baltimore Ave. Baltimore, Md.</u>	
DATE <u>3/20/57</u>		M.D. <u>W. J. Halstead</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/21/57</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		LOCATION (City, town, or county) (State) <u>A.A. County Md.</u>	
24. REC'D BY REGISTRAR <u>3/20/57</u>		REGISTRAR'S SIGNATURE <u>L. J. Sealby</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>A. Halstead</u>		ADDRESS <u>918 Druid Hill Ave</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

A. FULL NAME OF DECEASED

B. PLACE OF DEATH

C. FULL NAME OF PERSON REPORTING DEATH

D. RELATIONSHIP

E. PLACE OF BIRTH

F. DATE OF BIRTH

G. PLACE OF BIRTH

H. PLACE OF BIRTH

I. PLACE OF BIRTH

J. PLACE OF BIRTH

K. PLACE OF BIRTH

L. PLACE OF BIRTH

M. PLACE OF BIRTH

N. PLACE OF BIRTH

O. PLACE OF BIRTH

P. PLACE OF BIRTH

Q. PLACE OF BIRTH

R. PLACE OF BIRTH

S. PLACE OF BIRTH

T. PLACE OF BIRTH

U. PLACE OF BIRTH

V. PLACE OF BIRTH

W. PLACE OF BIRTH

X. PLACE OF BIRTH

Y. PLACE OF BIRTH

Z. PLACE OF BIRTH

BUREAU V. 5

MAR 21 1957

RECEIVED

SECRET

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02462

2449 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>13 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Friendship</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>GERMAN</u> (Middle) <u>L</u> (Last) <u>BOWEN</u>				(Month) <u>March</u> (Day) <u>17</u> (Year) <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 30, 1886</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Benjamin Bowen</u>				14. MOTHER'S MAIDEN NAME <u>Florence Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-36-3401</u>		17. INFORMANT & ADDRESS <u>Brince Frederick, Md.</u> <u>Mrs Alen Wood- Edwards</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Ac + Chl - Congestion fail lun</u>						<u>36 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Anterior cholecystitis C U</u>						<u>gn.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Uremia due to B.P.H.</u>						<u>5 yr.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/14/57</u> , 19 <u>57</u> , to <u>3/17/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/16/57</u> , 19 <u>57</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above. <u>3/17/57</u>							
SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city, town, state) <u>M.D. 63 College Ave Annapolis Md</u>		DATE SIGNED <u>3/17/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 20, 57</u>		NAME OF CEMETERY OR CREMATORY <u>Wesley Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince Frederick, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Mar. 19, 57</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.H. Hutchens</u> ADDRESS <u>Owings, Maryland</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

NAME OF DECEASED

BUREAU V. S.

MAR 26 1957

RECEIVED

2489 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Co. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenthiams Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenthiams Heights</u>			
c. LENGTH OF STAY IN 1b <u>6 mo</u>				d. STREET ADDRESS <u>410 Forest View Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>410 Forest View Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARIAN COLE BRANDT</u>				4. DATE OF DEATH <u>March 13 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 15, 1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Muse</u>				14. MOTHER'S MAIDEN NAME <u>Isabella Ursula</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>410 Forest View Road</u>		17. INFORMANT <u>Grace A. Stauffer</u> Address <u>410 Forest View Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.0</u> DUE TO (c) <u>420.0</u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>14 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 1956</u> , to <u>March 13, 1957</u> , that I last saw the deceased alive on <u>3-13</u> , 1957, and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. J. Grimaldi</u> M.D.				ADDRESS (Street, city or town, state) <u>4609 Gov. Ritchie Highway</u> DATE SIGNED <u>3-13-57</u>			
PHYSICIAN'S NAME (Type) <u>P. J. GRIMALDI</u>				Baltimore 25, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		22d. LOCATION (City, town, or county) (State) <u>Balt Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Temple</u> ADDRESS <u>5311 Edmondson Ave</u>				24a. REC'D BY REGISTRAR <u>15 57</u>		24b. REGISTRAR'S SIGNATURE <u>Outman</u>	

BUREAU V. S.

MAR 15 1957

RECEIVED

2490 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis P.F.D. 4</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis P.F.D. 4 Md</u>			
f. STREET ADDRESS				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>E.</u> Last <u>Bruce Sr.</u>				4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-1889</u>		9. AGE (In years last birthday) <u>68</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanical</u>		11. BIRTHPLACE (State or foreign country) <u>aa Co Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Richard Silberman Bruce</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Stinecomb</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Norman E. Bruce Jr</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis generalized</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 1, 1954</u> to <u>March 10, 1957</u> ; that I last saw the deceased alive on <u>3-9-1957</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 SHAW ST ANNAPOLIS, MD</u> DATE SIGNED <u>3/11/57</u>							
ACTUAL SIGNATURE <u>James H. Smith</u> M.D.							
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar-12-57</u>		<u>Cedar Bluff</u>		<u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>				ADDRESS <u>Annapolis Md</u>		24. REC'D BY REGISTRAR DATE <u>12 1957</u>	
25. REGISTRAR'S SIGNATURE <u>J. H. Smith</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02465

2491 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sandy Point Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>03x02 Baltimore</i> ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Against the jetty</i>		d. STREET ADDRESS <i>2123 Sparrows Point Rd.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Jimmie Myers Campbell</i>		4. DATE OF DEATH Month Day Year <i>March 22 1957 19</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/28/28</i>
9. AGE (In years last birthday) <i>28</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BUS DRIVER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>TRANSIT</i>	11. BIRTHPLACE (State or foreign country) <i>Standford, West Va.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>HENRY CAMPBELL</i>	
14. MOTHER'S MAIDEN NAME <i>NINA COFFEY</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>FAMILY</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>929.9</i> IMMEDIATE CAUSE (a) <i>Drowning</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>William Upchurch</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>MARCH 24, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>FORT HILL MEM PARK</i>		22d. LOCATION (City, town, or county) (State) <i>LYNCHBURG VIRGINIA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>WHITTEN FUNERAL HOME INC. LYNCHBURG, VA.</i>		24a. REC'D BY REGISTRAR <i>DATE MAR 26 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>H. H. Hedrick</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

RECEIVED

2492

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) A.A. COUNTY		c. LENGTH OF STAY IN IB 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PLAZA MANOR CONV. HOME		d. STREET ADDRESS 1509 Lemon ST.	
3. NAME OF DECEASED (Type or print) First JOHN Middle CARROLL Last		4. DATE OF DEATH Month Mar Day 23 Year 1957	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Carroll		14. MOTHER'S MAIDEN NAME Margaret Fletcher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George Carroll		Address Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS GENERAL DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 13, 1957 to Mar 23, 1957 , that I last saw the deceased alive on Mar 19, 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Taler M.D.		ADDRESS (Street, city or town, state) 102 Balto - Annap. Blvd. Md. 3-2357	
PHYSICIAN'S NAME (Type) JOSEPH TALER		DATE SIGNED Green Burwie, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-29-57	22c. NAME OF CEMETERY OR CREMATORY mt. Zion Cemetery	22d. LOCATION (City, town, or county) (State) Balt. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Jackson ADDRESS Funeral Home 916 Penna. Ave		24a. REC'D BY REGISTRAR MAR 27 1957 DATE	
		24b. REGISTRAR'S SIGNATURE L. J. Adlberg	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

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BUREAU V. S.

MAR 27 1957

RECEIVED

2447 CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rural Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOA Anne Arundel General Hospital		d. STREET ADDRESS 1 Rt 4 Box 466	
3. NAME OF DECEASED (Type or print) ELEANORA First ELEAN Middle CASE Last (CHASE)		4. DATE OF DEATH Month March Day 8 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1955
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Month 11 Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Atlanta, Georgia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William H. Case	
14. MOTHER'S MAIDEN NAME Ethle Mae Riscalla		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none (If yes, give war or dates of service) none	
16. SOCIAL SECURITY NO. none		17. INFORMANT William H. Case- Father- same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus DUE TO 921.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Upper respiratory infection			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Regurgitated food and aspirated while asleep on couch	
20c. TIME OF INJURY Month, Day, Year Hour 11 a. m. 3/8/57 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Annapolis A. A. Md.
21. I certify that I attended the deceased from 3-8-57 , 19 , to 3-8-57 , 19 , that I last saw the deceased alive on 3-8-57 , 19 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Neil H. Sims, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 95 Cathedral St. Annapolis, Md.	
PHYSICIAN'S NAME (Type) NEIL H. SIMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 3-9-57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	22d. LOCATION (City, town, or county) (State) Prince George County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		24a. REC'D BY REGISTRAR Mar 11 1957	
ADDRESS Annapolis, Md.		24b. REGISTRAR'S SIGNATURE Ann. J. French	

CERTIFICATE OF DEATH

Name of Deceased (Print Name)		Date of Death (Month, Day, Year)	
Sex Male / Female		Race (Print Race)	
Date of Birth (Month, Day, Year)		Place of Birth (City, State, Country)	
Usual Residence (Street, City, State, Zip)		Place of Death (City, State, Country)	
Cause of Death (List Cause of Death)		Manner of Death (Natural, Accidental, Suicide, Homicide, Undetermined)	
Physician's Signature (Print Name)		Medical Examiner's Signature (Print Name)	
Date of Signature (Month, Day, Year)		Date of Signature (Month, Day, Year)	

BUREAU V. 2

MAR 11 1957

RECEIVED

CERTIFICATE OF DEATH

2493

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		STATE Maryland		COUNTY Anne Arundel			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Millersville		LENGTH OF STAY (in this place) 1 week		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sanns Nursing Home		STREET ADDRESS 2062 West Street		(If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JAMES (Middle) SAMUEL (Last) COALE				(Month) MARCH (Day) 21 (Year) 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 7, 1878	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Prince George County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas E. Coale				14. MOTHER'S MAIDEN NAME Willie Suit			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. - - - -		17. INFORMANT & ADDRESS Mrs Mildred Thompson- Daughter- Bowie, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2 days	
331X IMMEDIATE CAUSE (A) Cerebral Accident							
ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar 19, 1957 , to Mar 21, 1957 , that I last saw the deceased alive on Mar 19, 1957 , and that death occurred at 5:30 AM , from the causes and on the date stated above.							
SIGNATURE Edward J. Bennett		M.D.		ADDRESS (Street, city, town, state) Lebanon Rd		DATE SIGNED 3-21-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-23-57		NAME OF CEMETERY OR CREMATORY Mt. Zion Methodist Cem.		LOCATION (City, town, or county) (State) Lothian, Maryland	
24. REC'D BY REGISTRAR DATE MAR 22 1957		REGISTRAR'S SIGNATURE H. M. Joyce		25. FUNERAL DIRECTOR'S SIGNATURE CHOPPING FUNERAL HOME		ADDRESS Annapolis, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

2000-01-01

1. *Chlorophyll a* (Chl *a*)

TABLE 2

• , 1990 1990 1990

3-22-63

BUREAU V. B.

MAR 22 1957

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2494
CERTIFICATE OF DEATH

02469

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort George G. Meade</u>		LENGTH OF STAY (in this place) <u>4 hrs 23 min</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Odenton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>Fort Meade Cabins</u>			
3. NAME OF DECEASED (Type or Print) <u>LINDA GAIL COWARD</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 18 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>17 March 1957</u>		9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days <u>4 23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ralph Ellridge Coward</u>				14. MOTHER'S MAIDEN NAME <u>Joyce Marie Doigg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father, Fort Meade Cabins, Odenton, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
776X IMMEDIATE CAUSE (A) <u>Immaturity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs 23 min</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>17 Mar</u> <u>19 57</u> to <u>18 Mar</u> <u>19 57</u> that I last saw the deceased alive on <u>18 Mar</u> <u>19 57</u> and that death occurred at <u>1:50 AM</u> from the causes and on the date stated above. SIGNATURE <u>JOSEPH B. BRILL, MD</u> <u>0150 AM</u> ADDRESS (Street, city, town, state) DATE SIGNED <u>Joseph B. Brill</u> M.D. <u>USAH, Fort G. G. Meade, Md.</u> <u>18 March 57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u># 3.21.57</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
24. REC'D BY REGISTRAR DATE <u>18 Mar 57</u>		REGISTRAR'S SIGNATURE <u>W.L. SAILOR, 1ST LT, MSC</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Inc. 1217 St. Paul Street Balto 2</u>			

2050243XV0

BUREAU A. S.

MAR 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2448 CERTIFICATE OF DEATH

Reg. Dist. No.

02470

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OSCAR R. Vaughan Dawes</u>		4. DATE OF DEATH Month Day Year <u>3-11-57</u> 19	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hardware Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Meredith Dawes</u>		14. MOTHER'S MAIDEN NAME <u>W. Amanda Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes; no, or unknown) <u>U.S. Army 1918-1919</u>		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>	
17. INFORMANT <u>Wife Mrs. Marion Dawes</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma Prostate & Extension</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19____, to <u>1957</u> , 19____, that I last saw the deceased alive on <u>3-10-57</u> , 19____, and that death occurred at <u>12:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Halpin</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md.</u>	
DATE SIGNED <u>3-11-57</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. HALPIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-14-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Annes Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sins</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D BY REGISTRAR <u>12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. ...</u>	

BUREAU V. S.

1937 3

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2495 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Items 1, 9, Film 212 3-15-57 et

02471
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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Jessup</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fort Meade Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>W.</u> Last <u>Dawson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1893</u> 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM FRANK DAWSON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Fort Meade Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis of the heart and blood vessels</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>422.1</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>William V. Gault</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-5-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Douglas Memorial Park</u>
		22d. LOCATION (City, town, or county) <u>Cambridge</u>	(State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Home</u>		24. REC'D BY REGISTRAR <u>John M. Gault</u>	
ADDRESS <u>Cambridge Md.</u>		25. REGISTRAR'S SIGNATURE <u>Clara Gault</u>	

MEDICAL CERTIFICATION

AMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Medical Examiner's Office along with form PM3. Page 3 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: Give the certificate to the Medical Examiner's Office along with form PM3. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for the examiner's signature and notes.

BUREAU V. S.

MAR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2449 CERTIFICATE OF DEATH

02472

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS.				c. LENGTH OF STAY IN TB 14 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUNRAISE BEACH	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GEN.				d. STREET ADDRESS 1833 DO PLAR DR		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DOROTHY Middle M Last DODA				4. DATE OF DEATH Month MARCH Day 25 Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-8-19	
				9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N.W.F.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME RALPH SCHUYLER				14. MOTHER'S MAIDEN NAME LORETTA DASH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service				16. SOCIAL SECURITY NO. ms. Mary Ella Cook - Greentown			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 002X DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from MARCH 22, 1957 , to MARCH 25, 1957 , that I last saw the deceased alive on MARCH 25, 1957 , and that death occurred at 12:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Maurice F. Klawans M.D.				ADDRESS (Street, city or town, state) 31 Southgate Ave. Annapolis, Md.			
DATE SIGNED 3/25/57							
PHYSICIAN'S NAME (Type) MAURICE F. KLAWANS							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Mar. 30		Centreville		Centreville Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane ADDRESS Church Hill, Md.				24a. REC'D BY REGISTRAR APR 2 1957		24b. REGISTRAR'S SIGNATURE Thm. J. French	

BUREAU A. S.

1957 2

RECEIVED

2450 CERTIFICATE OF DEATH

02473

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>6 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Estelle</i> Last <i>Donnell</i>				4. DATE OF DEATH Month <i>3</i> Day <i>26</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/18/08</i>	
9. AGE (In years last birthday) <i>49 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Cumbersstone MD</i>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <i>Wm. Neale</i>				14. MOTHER'S MAIDEN NAME <i>Hattie Foote</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>John W. Donnell Box 453 Edgewater MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension, arteriosclerosis</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>3-25-57</i> , 19 <i>57</i> , to <i>3-26-57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>3-25-57</i> , 19 <i>57</i> , and that death occurred at <i>5:30</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>A. T. Allen</i> M.D. <i>62 Bethesda St</i> DATE SIGNED <i>3-30-57</i> PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>4/2/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Chews</i>		22d. LOCATION (City, town, or county) (State) <i>West River MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Bernard H. Harty Salisbury Md</i>				24a. REC'D BY REGISTRAR DATE <i>4/3/57</i>		24b. REGISTRAR'S SIGNATURE <i>John W. Donnell</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02474

2496 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena RFD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *2 Pasadena RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mountain Rd. @ Tickneck Road		d. STREET ADDRESS Mountain Rd. @ Tickneck Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMMA Middle VIRGINIA Last DUNLAP		4. DATE OF DEATH Month March Day 25 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1877
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Ellison		14. MOTHER'S MAIDEN NAME Sarah E. Osborne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Samuel E. Dunlap		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic, hypertensive cardio DUE TO vascular disease (c) 5 years -		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized glandular enlargement - Carcinoma?		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 20, 1950 , to March 25, 1957 , that I last saw the deceased alive on March 24, 1957 , and that death occurred at 10:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. McLaughlin M.D.		ADDRESS (Street, city or town, state) Pasadena, Md. DATE SIGNED Mar 25, 1957	
PHYSICIAN'S NAME (Type) R.M. McLaughlin M.D.		Pasadena, Maryland March 25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 27/57	
22c. NAME OF CEMETERY OR CREMATORY Magothy Ch. Cem.		22d. LOCATION (City, town, or county) (State) Mountain Road, AACo., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR [Signature] DATE March 28, 1957	
		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

MAR 29 1957

BUREAU V. S.

RECEIVED

MARYLAND

02475
STATE DEPARTMENT OF HEALTH

2497 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>White Hall Beach</u> LENGTH OF STAY (in this place) <u>4 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Whitehall Beach</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beach</u>		STREET ADDRESS (If rural, give location) <u>Annapolis md</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Anna</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 11 - 57</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>4 March 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>89</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. FATHER'S NAME <u>Valentine Koenig</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
16. SOCIAL SECURITY No. <u>no</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
		17. INFORMANT AND ADDRESS <u>Daughter Mrs Wellman Beach</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(a) <u>Respiratory Failure</u> (b) <u>Marked Generalized Arteriosclerosis</u> (c) <u>Senility</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1955, 19....., to....., 19....., that I last saw the deceased alive on 2 March 57 and that death occurred at 7:30 A.M., from the causes and on the date stated above.

SIGNATURE Robert R. Hall (Degree or title) ADDRESS Severna Park Md DATE SIGNED 3-11-57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>Mar -14-57</u>	<u>St. Lincoln</u>	<u>Prince George Co Md</u>
DATE REC'D BY LOCAL REG	REGISTER'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>MAR 11 1957</u>	<u>[Signature]</u>	<u>John M. Taylor</u>	<u>Annapolis md</u>

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

TELEPHONE (202) 547-6000

TELETYPE (202) 547-6000

FACSIMILE (202) 547-6000

MAIL ROOM (202) 547-6000

RECORDS MANAGEMENT (202) 547-6000

GENERAL INVESTIGATIVE DIVISION

IDENTIFICATION DIVISION

LABORATORY DIVISION

TRAINING DIVISION

ADMINISTRATIVE DIVISION

COMMUNICATIONS DIVISION

INVESTIGATIVE DIVISION

IDENTIFICATION DIVISION

LABORATORY DIVISION

TRAINING DIVISION

ADMINISTRATIVE DIVISION

RECEIVED
MAR 13 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02476

2451 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>100 Spa View Ave</u>		d. STREET ADDRESS <u>105 Spa View Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Ummie</u> Middle <u>Frances</u> Last <u>Ellinghausen</u>		4. DATE OF DEATH Month <u>3</u> - Day <u>16</u> - Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4-1873</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>"Uck"</u>		14. MOTHER'S MAIDEN NAME <u>"Uck"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>HERMAN ELLINGHAUSEN</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio-Vascular -</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal Disease & Decompensation</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 12, 1955</u> , to <u>March 16, 1957</u> , that I last saw the deceased alive on <u>March 13, 1957</u> , and that death occurred at <u>3:00 A. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans, M.D.</u>		ADDRESS (Street, city or town, state) <u>31 Smithgate Ave Annapolis, Md.</u>	
DATE SIGNED <u>3/16/57</u>			
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS,</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-18-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>JO - J. J. Smith</u>		24b. REGISTRAR'S SIGNATURE <u>JO - J. J. Smith</u>	
DATE <u>MAR 18 1957</u>			

RECEIVED

RECEIVED

2452

CERTIFICATE OF DEATH

02477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7 Wardour Drive</u>				d. STREET ADDRESS <u>17 Wardour Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Edward Emery</u>				4. DATE OF DEATH Month Day Year <u>3 - 23 - 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 - 8 - 1897</u>	
9. AGE (In years last birthday) yrs. <u>34</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>St. L. N. S. M. C.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>St. L. N. S. M. C.</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Livingston Emery</u>				14. MOTHER'S MAIDEN NAME <u>Polly C. Pratt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>Mar I - II</u>		17. INFORMANT Address <u>Dorothy G. Emery</u> (3)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung with</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized metastasis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>52</u> , to <u>3-20</u> , 19 <u>57</u> that I last saw the deceased alive on <u>3-20</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.				ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD.</u>			
DATE SIGNED <u>3/25/57</u>							
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3 - 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>7th Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylorsons</u>				ADDRESS <u>Annapolis MD</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>J. J. J. J.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to the funeral director for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 27 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 2498

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> TOWN <u>Glen Burnie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#3 North Meadow Drive</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> OR TOWN <u>Glen Burnie</u> STREET ADDRESS (If rural give location) <u>#3 North Meadow Drive</u>	
3. NAME OF DECEASED (Type or Print) <u>John LUTHER F E D D O N</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>MARCH 11</u> 19 <u>57</u> (Month) (Day) (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN 10, 1900</u> 57 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>John Edward F E D D O N</u>		14. MOTHER'S MAIDEN NAME <u>MARY VIRGINIA MOONMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-04-7826</u>	
		17. INFORMANT & ADDRESS <u>Lda F E D D O N - Same</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <u>Cardiac Failure</u>			<u>30 MIN</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Thrombosis</u>			<u>1 hr.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Arteriosclerotic Heart Disease</u>			<u>5 yrs</u>
STATING UNDERLYING CAUSE LAST. <u>Essential Hypertension</u>			<u>10 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/31</u> , 19 <u>56</u> , to <u>3/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/4</u> , 19 <u>57</u> , and that death occurred at <u>4:10 P.</u> M. from the causes and on the date stated above.			
SIGNATURE <u>W. Prichard</u>		ADDRESS (Street, city, town, state) <u>715 Cottage Rd. Glen Burnie Md</u> DATE SIGNED <u>3/14/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		NAME OF CEMETERY OR CREMATORY <u>TRINITY EPISCOPAL</u> LOCATION (City, town, or county) <u>UPPER MARLBOROUGH, MD</u>	
24. REC'D BY REGISTRAR <u>MAR 14 1957</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook</u> ADDRESS <u>1211 St. Paul St</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completed and filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MAR 14 1957

RECEIVED

MAR 14 1957

BUREAU V. S.

CERTIFICATE OF DEATH

REYNOLDS STATE DEPARTMENT OF HEALTH-BALTIMORE 13

Reg. Dist. No.

2. Usual Residence (House or Apartment)

3. Place of Birth

4. Date of Birth

5. Sex

6. Cause of Death (Immediate Cause)

7. Date of Death

8. Time of Death

9. Place of Death

10. Sex

11. Cause of Death (Immediate Cause)

12. Date of Death

13. Time of Death

14. Place of Death

15. Sex

16. Cause of Death (Immediate Cause)

17. Date of Death

18. Time of Death

19. Place of Death

20. Sex

21. Cause of Death (Immediate Cause)

22. Date of Death

23. Time of Death

24. Place of Death

25. Sex

26. Cause of Death (Immediate Cause)

27. Date of Death

28. Time of Death

29. Place of Death

30. Sex

31. Cause of Death (Immediate Cause)

32. Date of Death

33. Time of Death

34. Place of Death

35. Sex

36. Cause of Death (Immediate Cause)

37. Date of Death

38. Time of Death

39. Place of Death

40. Sex

41. Cause of Death (Immediate Cause)

42. Date of Death

43. Time of Death

44. Place of Death

45. Sex

46. Cause of Death (Immediate Cause)

47. Date of Death

48. Time of Death

49. Place of Death

50. Sex

51. Cause of Death (Immediate Cause)

52. Date of Death

53. Time of Death

54. Place of Death

55. Sex

56. Cause of Death (Immediate Cause)

57. Date of Death

58. Time of Death

59. Place of Death

60. Sex

61. Cause of Death (Immediate Cause)

62. Date of Death

63. Time of Death

64. Place of Death

65. Sex

66. Cause of Death (Immediate Cause)

67. Date of Death

68. Time of Death

69. Place of Death

70. Sex

71. Cause of Death (Immediate Cause)

72. Date of Death

73. Time of Death

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her last illness. It should be filled out as soon as possible after death, and should be filed with the local health department. 2. The cause of death should be stated in as much detail as possible, and should be based on the physician's own knowledge and the results of any post-mortem examination. 3. The place of death should be stated as the place where the deceased died, and not the place of birth or residence. 4. The sex should be stated as male or female. 5. The date of death should be stated in full, including the day, month, and year. 6. The time of death should be stated in full, including the hour, minute, and second. 7. The instructions on the back of this certificate should be read carefully. 8. This certificate is a legal document, and its contents should be true and correct. 9. The physician or other qualified person who fills out this certificate is responsible for its accuracy. 10. This certificate is valid for a period of one year from the date of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2453

Item 7 Film 6212 3-26-57 et

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 02479

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 310 Chesapeake Avenue			
3. NAME OF DECEASED (Type or print) ALBERT FISHER LOUIS				4. DATE OF DEATH Month March Day 17 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2-1931	
9. AGE (In years last birthday) 25 yrs.		10. IF UNDER 1 YEAR Months 25 Days 25 Hours 25 Min.		11. BIRTHPLACE (State or foreign country) Annapolis Md		12. CITIZEN OF WHAT COUNTRY? U. S. A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY Grabs-Cyprus			
13. FATHER'S NAME Charles W. Fisher				14. MOTHER'S MAIDEN NAME Lucille Monday			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES 1957-1954				16. SOCIAL SECURITY NO. 1957-1954			
17. INFORMANT Charles W. Fisher				Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Hemoperitoneum secondary to Ruptured Liver 812X INDEXOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto.			
20c. TIME OF INJURY Month, Day, Year 9:35 P.M. 3/17 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Partial A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 3/18/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar-20-1957		22c. NAME OF CEMETERY OR CREMATORY Wheatcrest		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons				24a. REC'D BY REGISTRAR 3/19/57			
ADDRESS Annapolis Md				24b. REGISTRAR'S SIGNATURE V. O. Smith			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Anna Arnold		March 20, 1957	
Place of Death		Place of Birth	
Anna Arnold General Hospital		Maryland	
Cause of Death		Occupation	
Heart Failure		Housewife	
Manner of Death		Sex	
Natural		Female	
Age at Death		Color	
72		White	
Height		Weight	
5' 0"		125 lbs	
Build		Education	
Slender		High School	
Marital Status		Religion	
Married		Catholic	
Date of Marriage		Signature of Examiner	
1915		[Signature]	
Address of Deceased		Signature of Physician	
310 Chesapeake Avenue		[Signature]	
City		Signature of Coroner	
Baltimore		[Signature]	
County		Signature of Registrar	
Baltimore		[Signature]	

BUREAU V. 2
 MAR 20 1957
RECEIVED

2454 CERTIFICATE OF DEATH

02480

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>x2 Three Mile Oak</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. General</u>				d. STREET ADDRESS <u>P.F.D.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>D.</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1905</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor & Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homes</u>		11. BIRTHPLACE (State or foreign country) <u>Melford Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Mary Loomis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Edna D. Fisher</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. myocardial infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u> <u>18 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/2</u> , 19 <u>57</u> , to <u>3/3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/3</u> , 19 <u>57</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Maurice F. Krawans</u>		M.D. <u>Annapolis, Md</u>		DATE SIGNED <u>3/4/57</u>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KRAWANS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemt</u>		22d. LOCATION (City, town, or county) (State) <u>Melford Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3/5/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Brown</u>			

CERTIFICATE OF DEATH

COUNTY OF <u>MASSACHUSETTS</u> STATE OF <u>MASSACHUSETTS</u>		DECEASED <u>JOHN J. BROWN</u>	
DATE OF DEATH <u>MAY 15 1957</u> PLACE OF DEATH <u>AT HOME</u>		AGE <u>68</u> SEX <u>MALE</u>	
OCCUPATION <u>RETIRED</u> CAUSE OF DEATH <u>HEART DISEASE</u>		MANNER OF DEATH <u>NATURAL</u> PLACE OF BIRTH <u>MASSACHUSETTS</u>	
SIGNATURE OF DECEASED <u>[Signature]</u> SIGNATURE OF WITNESS <u>[Signature]</u>		SIGNATURE OF PHYSICIAN <u>[Signature]</u> SIGNATURE OF CORONER <u>[Signature]</u>	
SIGNATURE OF REGISTRAR <u>[Signature]</u> SIGNATURE OF CLERK <u>[Signature]</u>		SIGNATURE OF JURY <u>[Signature]</u> SIGNATURE OF JUDGE <u>[Signature]</u>	

BUREAU V. 5

MAR 7 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02481

2499 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notwell</u>		LENGTH OF STAY (in this place) <u>70 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notwell</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>SUSAN REBECCA FORD</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 25 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>OCT 9 1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Prince George Co Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jesse TROTT</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Ann WILKERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Annie S. Gibson, Tracy's Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15 Mar, 1957</u> , to <u>25 Mar, 1957</u> , that I last saw the deceased alive on <u>25 Mar, 1957</u> , and that death occurred at <u>.....M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Upper Marlboro Md</u>		DATE SIGNED <u>26-3-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/28/57</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		LOCATION (City, town, or county) (State) <u>Friendship MD</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Galesville Md</u>	
DATE <u>MAR 28 1957</u>							

42181

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

Form No. 1

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

PLACE OF DEATH

MARYLAND

COUNTY

CITY

STREET

DATE OF DEATH

TIME OF DEATH

AGE

DATE OF DEATH

SEX

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

IMMEDIATE

INTERMEDIATE

FINAL

CAUSE OF DEATH

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CAUSE OF DEATH

BUREAU V. S.

MAR 29 1957

RECEIVED

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02482

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND		CITY OR TOWN <u>FORT GEO, G. MEADE, 4 HOURS</u>		STATE <u>VIRGINIA</u> MARYLAND COUNTY <u>Norfolk</u> ANNE ARUNDEL		CITY OR TOWN <u>83X-3</u> Norfolk XXXXXXXXXX MEADE, XXXXID.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. ARMY HOSPITAL</u>				STREET ADDRESS <u>3315 Kansas Avenue</u> 1065 XXXXXX XXXX MEADE, XXXX			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JANET LEE FRANCIS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3/11/57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>—</u>	8. DATE OF BIRTH <u>3/11/57</u>	9. AGE last birthday <u>—</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min. <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>RICHARD W. FRANCIS</u>				14. MOTHER'S MAIDEN NAME <u>BERWICE C. PUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>FATHER, 1565 CARVEL AVE, MD, FORT MEADE,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>776X Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>—</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>—</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>—</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>11 Mar</u> , 19 <u>57</u> , to <u>11 Mar</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11 Mar</u> , 19 <u>57</u> , and that death occurred at <u>4:49</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>THOMAS A. COOK, JR. MD</u>				DATE SIGNED <u>U.S. ARMY HOSPITAL, FORT GEO. G. MEADE, MD.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Mar. 12, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Balto. Natl</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>—</u>		REGISTRAR'S SIGNATURE <u>William W. Sawyer, Lt. H</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WM COOKE, INC, Baltimore, Maryland</u>			
DATE <u>3/11/57</u>							

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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02483

02501

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>PENNSYLVANIA</u>		COUNTY <u>Clearfield</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
TOWN <u>Fort George G. Meade</u>				CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>DuBois</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
<u>U. S. Army Hospital</u>				<u>114 W. 2nd Avenue</u>		<u>Laurel Park Hotel</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>DONN</u> (Middle) <u>DOUGLAS</u> (Last) <u>FRENCH</u>				(Month) <u>March</u> (Day) <u>18</u> (Year) <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>17 March 1957</u>		Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Gary Neil French, Sr.</u>				<u>Dorothy Jean Cable</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Father, Laurel Park Hotel, Laurel, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
762.5 IMMEDIATE CAUSE (A) <u>Anoxia</u> <u>Anoxia</u>						<u>12 hours (est.)</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO						<u>33 3/4 hours</u>	
(C) <u>Immaturity</u> <u>Immaturity</u>						<u>33 3/4 hours</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>17 March, 19 57</u> , to <u>18 March, 19 57</u> , that I last saw the deceased alive on <u>18 March, 19 57</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>RICHARD M. MCGUANE, Capt, MC</u>				ADDRESS (Street, city, town, state) <u>2101-150, USAF, Ft. Meade, Md</u>			
DATE SIGNED <u>18 Mar 57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3.21.57</u>		<u>Morningside</u>		<u>DuBois Pa.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>19 Mar 57</u>		<u>W.L. Saylor, 1st Lt, MSC</u>		<u>Wm. Cook Inc. 1217 ST. PAUL STREET</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Usual Residence (Home or Hospital)

2. Date of Death

3. Cause of Death

4. Place of Death

5. Age at Death

6. Sex

7. Race

8. Occupation

9. Marital Status

10. Date of Birth

11. Date of Admission

12. Date of Discharge

13. Date of Death

14. Date of Death

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BUREAU V. S.

MAR 21 1957

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RECEIVED

1. Name of Deceased
2. Date of Death
3. Cause of Death
4. Place of Death
5. Age at Death
6. Sex
7. Race
8. Occupation
9. Marital Status
10. Date of Birth
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MEDICAL CERTIFICATION

02484

02592

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Green</u> Last <u>Green</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-1879</u>
9. AGE (In years last birthday) <u>77 1/2</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm (Self)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Davidsonville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Green</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive failure, cardiac</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>2-9-57</u> , 19 <u> </u> , to <u>2-16-57</u> , 19 <u> </u> , that I last saw the deceased alive on <u>2-16-57</u> , 19 <u> </u> , and that death occurred at <u>2:25</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.T. Allen</u>		ADDRESS (Street, city or town, state) <u>61 Chestnut St</u> DATE SIGNED <u>3-9-57</u>	
PHYSICIAN'S NAME (Type) <u>A.T. ALLEN</u>		M.D. <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>3-11-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville</u>		22d. LOCATION (City, town, or county) (State) <u>Davidsonville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Allen</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Smith</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
 CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]	
CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]		PLACE OF BIRTH [Faint handwritten place]	
OCCUPATION [Faint handwritten occupation]		EDUCATION [Faint handwritten education]		RELIGION [Faint handwritten religion]	
MARITAL STATUS [Faint handwritten status]		PREVIOUS MARRIAGES [Faint handwritten details]		PRESENT RESIDENCE [Faint handwritten address]	
DATE OF BIRTH [Faint handwritten date]		PLACE OF BIRTH [Faint handwritten place]		OCCUPATION [Faint handwritten occupation]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]	
CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]		PLACE OF BIRTH [Faint handwritten place]	
OCCUPATION [Faint handwritten occupation]		EDUCATION [Faint handwritten education]		RELIGION [Faint handwritten religion]	
MARITAL STATUS [Faint handwritten status]		PREVIOUS MARRIAGES [Faint handwritten details]		PRESENT RESIDENCE [Faint handwritten address]	

BUREAU V. 2

MAR 14 1935

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02485

2455 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md 10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Anne Arundel Gen. Hosp</i>		d. STREET ADDRESS <i>3 Maryland Ave</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>GRACE HART</i>		4. DATE OF DEATH Month Day Year <i>MARCH 11 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown about 63 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOME</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	11. BIRTHPLACE (State or foreign country) <i>ENGLAND</i>
13. FATHER'S NAME <i>Walter H. Heart</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>CHILD + BALD (LAWYERS)</i>		Address <i>ANNAPODIS, MD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer, it may be generalized</i> <i>175x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastasis</i> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>7</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2/27</i> , 1957, to <i>3/11</i> , 1957, that I last saw the deceased alive on <i>3/11</i> , 1957, and that death occurred at <i>6:50 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Maurice F. Klawans</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>31 SOUTHGATE AVE., ANNAPODIS, MD.</i>	
PHYSICIAN'S NAME (Type) <i>MAURICE F. KLAWANS, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>MARCH 12-1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>FORT LINCOLN</i>	22d. LOCATION (City, town, or county) (State) <i>PRINCE GEORGE CO MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor, Son</i>		24a. REC'D BY REGISTRAR <i>3/14/57</i>	
ADDRESS <i>Annapolis Maryland</i>		24b. REGISTRAR'S SIGNATURE <i>James</i>	

STATE CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. RACE White	
5. DATE OF BIRTH April 14, 1922		6. PLACE OF BIRTH Jackson, Mississippi	
7. DATE OF DEATH April 4, 1968		8. PLACE OF DEATH Memphis, Tennessee	
9. TIME OF DEATH 2:01 PM		10. CAUSE OF DEATH FIRE	
11. MANNER OF DEATH Accidental		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF CORONER [Signature]		14. SIGNATURE OF DEATH REGISTRAR [Signature]	
15. SIGNATURE OF WITNESS [Signature]		16. SIGNATURE OF WITNESS [Signature]	
17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF WITNESS [Signature]	
19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF WITNESS [Signature]	
21. SIGNATURE OF WITNESS [Signature]		22. SIGNATURE OF WITNESS [Signature]	
23. SIGNATURE OF WITNESS [Signature]		24. SIGNATURE OF WITNESS [Signature]	
25. SIGNATURE OF WITNESS [Signature]		26. SIGNATURE OF WITNESS [Signature]	
27. SIGNATURE OF WITNESS [Signature]		28. SIGNATURE OF WITNESS [Signature]	
29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF WITNESS [Signature]	
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RECEIVED
MAR 15 1968
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02486

2456 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7 Constitution Ave</i>		d. STREET ADDRESS <i>7 Constitution Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>William</i> Last <i>Keller</i>		4. DATE OF DEATH Month <i>March</i> Day <i>20</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 6 1882</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipefitter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Plumbing</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Keller</i>		14. MOTHER'S MAIDEN NAME <i>Dorothea Bishop</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —	
17. INFORMANT <i>Anthony W. Howes</i>		Address <i>#2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis general</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>1 yr.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <i>Oct</i> , 19 <i>55</i> , to <i>March 20</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7 Apr</i> , 19 <i>57</i> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <i>3/24/57</i> ACTUAL SIGNATURE <i>James R. Martin</i> M.D. <i>E. SHAW ST.</i> PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i> <i>ANNAPOLIS, MD.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>3-23-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		24a. REC'D BY REGISTRAR <i>22 MAR 1957</i>	
ADDRESS <i>800 Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>James</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

12460

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. PLACE OF DEATH</p>	
<p>7. OCCUPATION</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. DATE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. PLACE OF INTERMENT</p>		<p>16. NAME OF CEMETERY</p>	
<p>17. NAME OF FUNERAL HOME</p>		<p>18. NAME OF MINISTER</p>	
<p>19. NAME OF CHURCH</p>		<p>20. NAME OF FAMILY</p>	
<p>21. NAME OF NEAREST RELATIVE</p>		<p>22. NAME OF NEXT OF KIN</p>	
<p>23. NAME OF SPOUSE</p>		<p>24. NAME OF CHILDREN</p>	
<p>25. NAME OF GRANDCHILDREN</p>		<p>26. NAME OF OTHER RELATIVES</p>	
<p>27. NAME OF FRIENDS</p>		<p>28. NAME OF OTHER RELATIVES</p>	
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BUREAU V. 8

MAR 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2457 CERTIFICATE OF DEATH

Reg. Dist. No.

02487

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>a a</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>16 Severn Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Henry</i> Middle <i>Elmer</i> Last <i>Henneberger</i>		4. DATE OF DEATH Month <i>3</i> - Day <i>7</i> - Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 28 1884</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months <i>72</i> Days <i>72</i> Hours <i>72</i> Min.	IF UNDER 24 HRS. Months <i>72</i> Days <i>72</i> Hours <i>72</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Interior Decorator of Painting, Etc.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Henry Henneberger</i>		14. MOTHER'S MAIDEN NAME <i>Mary Demitz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>2</i>	
17. INFORMANT <i>Florence Henneberger</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inanition</i> DUE TO <i>331x</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <i>Cerebral Hemorrhage</i> (c) <i>Cerebral Arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>2 mos.</i> <i>2 mos.</i> <i>unknown</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>JAN</i> , 1955, to <i>7 MAR.</i> , 1957, that I last saw the deceased alive on <i>4 MAR.</i> , 1957, and that death occurred at <i>6 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward S. Beck</i>		ADDRESS (Street, city or town, state) <i>41 Southgate Ave</i>	
PHYSICIAN'S NAME (Type) <i>EDWARD S. BECK MD</i>		DATE SIGNED <i>3/10/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-11-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Green Haven Memorial</i>	22d. LOCATION (City, town, or county) (State) <i>Green Haven Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR <i>11 MAR 11 1957</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>J. J. Dunch</i>	

CERTIFICATE OF DEATH

1957

RECEIVED
BUREAU V. S.
 MAR 12 1957

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. DATE OF DEATH</p>	

1. PLACE OF DEATH a. COUNTY <i>AA</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A. A. General</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i> d. STREET ADDRESS <i>17 Marda Lane</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>E.</i> Middle <i>Roland</i> Last <i>Hopkins</i>		4. DATE OF DEATH Month <i>3</i> - Day <i>14</i> - Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug-31-1902</i>
9. AGE (In years last birthday) <i>54</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Plumber</i>	
13. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		14. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. FATHER'S NAME <i>Edgar E. Hopkins</i>		16. MOTHER'S MAIDEN NAME <i>Mary Hyde</i>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		18. SOCIAL SECURITY NO. <i>101-1-10101</i>	
19. INFORMANT <i>Irma A. Hopkins</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary disease</i> Conditions, if any, which gave rise to immediate cause (b) <i>Lead</i> (c) <i>Lead</i> DUE TO <i>Lead</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		DATE SIGNED <i>3-14-57</i>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-17-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Green Haven Memorial</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Sayler Sons</i>		24. REGISTRAR'S SIGNATURE <i>J. J. ...</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

RECEIVED

2459 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anne Arundel Annapolis		c. LENGTH OF STAY IN 1b X2 Housley Rd. (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 1 RFD Annapolis,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle HOUSLEY Last		4. DATE OF DEATH Month March Day 4 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 8, 1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brickmason		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Housley		14. MOTHER'S MAIDEN NAME Ellen West	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital record office		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 wks. 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/20 , 19 57 , to 3/4 , 19 57 , that I last saw the deceased alive on 3/4 , 19 57 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 90 Cathedral Street Annapolis, Md. DATE SIGNED 3/4/57			
ACTUAL SIGNATURE John H. Hedeman M.D.		DATE SIGNED 3/4/57	
PHYSICIAN'S NAME (Type) John Hedeman MD		ADDRESS 90 Cathedral Street Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 7, 57	22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery	22d. LOCATION (City, town, or county) (State) Annapolis, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR DATE 8 1957		24b. REGISTRAR'S SIGNATURE Am. J. French	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02503 CERTIFICATE OF DEATH

02480

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 41yrs. 4mos. 27days Baltimore City 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Not given			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Arianna Middle Howard Last Howard				4. DATE OF DEATH Month March Day 26 Year 1957			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given		9. AGE (In years last birthday) 76? yrs.	IF UNDER 1 YEAR Months - Days - Hours - Min. -	IF UNDER 24 HRS. Months - Days - Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. - - -		17. INFORMANT Hospital Records Address Crownsville State Hospital Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of large bowels DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/25 , 19 48 , to 3/26 , 19 57 , that I last saw the deceased alive on 3/25 , 19 57 , and that death occurred at 3:15 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/26/57							
ACTUAL SIGNATURE [Signature]			M.D. [Signature]				
PHYSICIAN'S NAME (Type) L. Benedict							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		3-28-57		St. Agnes Cemetery Baltimore, Md.		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]			ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE 4/2/57		24b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2460 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 218 N. Taylor Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THELMA Middle E Last JACKSON				4. DATE OF DEATH Month March Day 23 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1912	9. AGE (In years lost birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retail Drug Store		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Benchhoff				14. MOTHER'S MAIDEN NAME Lulu Delphoy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 226-36-8830		17. INFORMANT Address Mrs. Lulu Benchhoff - Mother- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of aneurysm of Circle of Willis 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/22/1957 to 3/22/1957 , that I last saw the deceased alive on 3/22/57 , 19 57 , and that death occurred at 11:58 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 63 College Ave Annapolis, Maryland DATE SIGNED 3/27/57							
ACTUAL SIGNATURE Frank M. Shipley M.D.				PHYSICIAN'S NAME (Type) Frank M. Shipley MD 63 College Ave Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-47		22c. NAME OF CEMETERY OR CREMATORY Dedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR MAR 27 1957		24b. REGISTRAR'S SIGNATURE Wm. J. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		39		JAN 5, 1928		MOBILE, ALABAMA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
CONTRACTOR		HIGH SCHOOL		MARRIED		METHODIST		WHITE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		100-457311	
TIME OF DEATH		HOURS		MINUTES		SECONDS		TEMPERATURE	
4:00 PM		4		00		00		98.6	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
MAR 27 1968
BUREAU V. 3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02492

2461 CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hosp</u>				d. STREET ADDRESS <u>21 Morris St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Jacobs</u> Last <u>Jacobs</u>				4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-13-1880</u>	
9. AGE (In years last birthday) yrs. <u>77</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Waterbury, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Nathaniel Jacob</u>			
14. MOTHER'S MAIDEN NAME <u>Louise Jacobs</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>216-16-8220</u>				17. INFORMANT Address <u>Marie Bradford - Annap., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brownouts</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-16-57</u> , 19 <u>57</u> , to <u>3-16-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-16-57</u> , 19 <u>57</u> , and that death occurred at <u>9:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G.T. Allen</u>				ADDRESS (Street, city or town, state) <u>69 Eastview</u>			
M.D. <u>3-18-57</u>				DATE SIGNED <u>3-18-57</u>			
PHYSICIAN'S NAME (Type) <u>A.T. ALLEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

BUREAU V. S.

MAR 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02504

CERTIFICATE OF DEATH

02493

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park		c. LENGTH OF STAY IN 1b 35 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Arundel Beach Road.		d. STREET ADDRESS Same	
3. NAME OF DECEASED (Type or print) First George Middle Zachriah Last Jacobs		4. DATE OF DEATH Month March Day 7th. Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/26/87
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape artist.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewin Henry Jacobs		14. MOTHER'S MAIDEN NAME Margeret Dressel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) World War # 1 Infantry.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Maude Jacobs (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General arteriosclerosis 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hypertensive cardio vascular diseases DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 6 , 1957, to March 7 , 1957, that I lost saw the deceased alive on 3/6/57 , 1957, and that death occurred at 4.15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glen Burnie, Md. DATE SIGNED 3/7/57			
ACTUAL SIGNATURE Gustave H. Faubert		M.D. Glen Burnie, Md.	
PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/11/57	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC. 715 Light St.		24a. REC'D BY REGISTRAR MAR 12 1957	
ADDRESS Baltimore-30, Md.		24b. REGISTRAR'S SIGNATURE L.J. Dralby	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

RECEIVED
MAR 12 1957
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2462 CERTIFICATE OF DEATH

02494

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cl A. General</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
		d. STREET ADDRESS <i>153 Fleet</i>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Helen</i> Middle <i>M. Jernigan</i> Last <i></i>		4. DATE OF DEATH Month <i>3</i> Day <i>9</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-24-1905</i>
9. AGE (In years last birthday) <i>52</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Ambrose Hubbard</i>		14. MOTHER'S MAIDEN NAME <i>Blanchard</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Blanche Drury</i>		Address <i>Lambills Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardiac Disease</i> DUE TO (c) <i>Obese</i>		INTERVAL BETWEEN ONSET AND DEATH <i>17 hrs</i> <i>1 yr 1</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-9-1957</i> to <i>3/9/1957</i> that I last saw the deceased alive on <i>3-9-1957</i> , and that death occurred at <i>114 P</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <i>6 SHAW ST ANNAPOLIS, MD.</i> <i>3/11/57</i>	
ACTUAL SIGNATURE <i>James R. Martin</i> M.D.			
PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-13-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>EDGAR BLUFF</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sons</i>		ADDRESS <i>Annapolis Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>12 1957</i>		24b. REGISTRAR'S SIGNATURE <i>J. C. Brown</i>	

BUREAU V. S.

MAR 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2463

CERTIFICATE OF DEATH

02495

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Cumherstone x 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. General Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>TYRONE S</u> Middle <u>JOHNSON</u> Last <u>JOHNSON</u>		4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-57</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR: Months <u>2</u> Days <u>16</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Alice Edwards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>George Johnson - Cumherstone, Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> (b) <u>—</u> (c) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-11-57</u> , 19 <u>57</u> , to <u>3-18-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-11-57</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Edinboro St Baltimore 57</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		DATE SIGNED <u>3-18-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-19-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopes Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Edgewater Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 19 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02496

02505

CERTIFICATE OF DEATH

Item 9 FilmG212 3-15-57 et

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Jewell md</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Jewell md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Frank</u> (Middle) <u>H.</u> (Last) <u>Jones.</u>				<u>3</u> - <u>6</u> - <u>1957</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE/MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug-10-1902</u>		9. AGE last birthday <u>54</u> <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmers.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Jones</u>				14. MOTHER'S MAIDEN NAME <u>Mary Reid.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>577-20-5630</u>		17. INFORMANT & ADDRESS <u>Pauline Jones. Jewell md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
154X IMMEDIATE CAUSE (A) <u>Adenocarcinoma rectosigmoid Colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>C Metastasis.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Multiple Polyps of Colon</u>						<u>?4</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-28</u>, 19<u>57</u>, to <u>23 Feb</u>, 19<u>57</u>, that I last saw the deceased alive on <u>23 Feb</u>, 19<u>57</u>, and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Edith Endrich</u> M.D.				ADDRESS (Street, city, town, state) <u>Shady Side, Md</u>		DATE SIGNED <u>3-7-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>3-9-57</u>		<u>Union Chapel AA Co</u>		<u>AA Co</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell. Prince Frederick Md</u>		ADDRESS	
DATE <u>3-9-57</u>							

Ddr Belle Denton

RECEIVED

RECEIVED
MAR 12 1957
BUREAU V. 8

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
MANNER OF DEATH		CAUSE OF DEATH	
DISEASE OR INJURY		MEDICAL HISTORY	
DATE OF DEATH		PLACE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		PLACE OF SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG212 3-15-57et

02497
28

02506

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2yrs.2mos.5days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3 V01-4		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital	
d. STREET ADDRESS 652 Vine Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Jones Last Jones		4. DATE OF DEATH Month 3 Day 5 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Factory	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Jones		14. MOTHER'S MAIDEN NAME Eliza Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Crownsville State Hospital		Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 522X DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Infarction, Arteriosclerosis, CVD, Decubiti			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/30/54 , 19____, to 3/5/57 , 19____, that I last saw the deceased alive on 3/4 , 19 57 , and that death occurred at 4:30 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/5/57 ACTUAL SIGNATURE Ludwig Benedict M.D. PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10	
22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chester Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Blair		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE H. M. Jones			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES J. JONES		Male		35		1922		New York		New York		New York		United States	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		TIME OF DEATH	
March 7, 1967		10:30 AM		New York		New York		New York		United States		March 7, 1967		10:30 AM	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		SEX	
Heart Disease		Natural		Teacher		High School		Catholic		White		White		Male	
DISEASES AND CONDITIONS PREEXISTING AT TIME OF DEATH		DISEASES AND CONDITIONS PRESENT AT TIME OF DEATH		DISEASES AND CONDITIONS PRESENT AT TIME OF DEATH		DISEASES AND CONDITIONS PRESENT AT TIME OF DEATH		DISEASES AND CONDITIONS PRESENT AT TIME OF DEATH		DISEASES AND CONDITIONS PRESENT AT TIME OF DEATH		DISEASES AND CONDITIONS PRESENT AT TIME OF DEATH		DISEASES AND CONDITIONS PRESENT AT TIME OF DEATH	
Hypertension		Myocardial Infarction		Coronary Artery Disease		Atherosclerosis		Diabetes Mellitus		Obesity		Smoking		Alcoholism	
No		Yes		Yes		Yes		Yes		Yes		Yes		Yes	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		TIME OF DEATH	
March 7, 1967		10:30 AM		New York		New York		New York		United States		March 7, 1967		10:30 AM	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		SEX	
Heart Disease		Natural		Teacher		High School		Catholic		White		White		Male	

BUREAU V. S.

MAR 8 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02498

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD b. COUNTY P.R.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 1-19-57-3-20-57		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST HYATTSVILLE 1615-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 63 Anne Arundel Gen Hosp				d. STREET ADDRESS 2811 Nicholson		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard R. Larrick				4. DATE OF DEATH MARCH 20 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store clerk		10b. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James S. Larrick				14. MOTHER'S MAIDEN NAME Nannie Showalter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Richard Larrick- Son- West Friendship, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SENILITY: ARTERIOSCLEROTIC CARDIO - 420.1 DUE TO VASC. DIS. & HYPERTENSION, AURICULAR FIBRILLATION, MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. HEART DUE TO (b) FIBRILLATION, MYOCARDIAL INFARCTION (c) HEART							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FX LT TIBIA: CONCUSSION & POSSIBLE BULBAR DAMAGE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AUTO ACCIDENT					
20c. TIME OF INJURY Month, Day, Year Hour 4:30 a.m. 1-19 1957		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) STREET		20f. (City or town) (County) (State) WOODLAND BEACH ANNE ARUNDEL MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE W.E. Landmesser				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-20-57	
EXAMINER'S NAME (Type) W.E. LANDMESSER JR				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> PRO Tem		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-57		22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		22d. LOCATION (City, town, or county) (State) Upperville, Virginia	
23. FUNERAL DIRECTOR'S NAME Hopping Funeral Home				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR 22 1957 24b. REGISTRAR'S SIGNATURE Am. J. Zuerch	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE NO. 21

Form with multiple sections for medical history, cause of death, and examiner information. Includes fields for name, age, sex, race, and date of death. The text is mirrored and difficult to read.

BUREAU V. 8

MAR 22 1957

RECEIVED

02507 CERTIFICATE OF DEATH

02499

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colerwater</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colerwater</u> X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Selby Blvd.</u>		d. STREET ADDRESS <u>Selby Blvd.</u> 1	
3. NAME OF DECEASED (Type or print) <u>Michael Washington Lindsay</u>		4. DATE OF DEATH <u>3</u> Month <u>29</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 May 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Danymon</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chutnut Farms</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Lindsay</u>		14. MOTHER'S MAIDEN NAME <u>Martha Murphy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578035190</u>	
17. INFORMANT <u>Martha Jones</u> Address <u>Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart failure</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 10, 1956</u> , to <u>March 29, 1957</u> , that I last saw the deceased alive on <u>Dec 29</u> , 19 <u>57</u> , and that death occurred at <u>8:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sylvia M. Lim</u> M.D. <u>RFD #1 Box 277-M Edgewater, 3/29/57</u>		ADDRESS (Street, city or town, state) <u>Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>4-1-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wm. Ober Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Jarch's Sons - Hyattsville, Md.</u>		24. REC'D BY REGISTRAR <u>APR 2 1957</u> 25. REGISTRAR'S SIGNATURE <u>John J. French</u>	

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. Includes checkboxes for "Stillborn" and "Fetus".

BUREAU V. S.

APR 2 1957

RECEIVED

578-03-5190

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2465 CERTIFICATE OF DEATH

Reg. Dist. No. 02500

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>148 Gloucester St.</u>		d. STREET ADDRESS <u>148 Gloucester St.</u>	
3. NAME OF DECEASED (Type or print) <u>Katherine E. Linthicum</u>		4. DATE OF DEATH <u>March 14 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1876</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David O. Parlett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louise Knight</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Thomas J. Linthicum III</u>		Address <u>(2)</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>422.1</u> DUE TO <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio Sclerosis</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Some months</u> <u>Several yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-7, 1957, to 3-14, 1957, that I last saw the deceased alive on 3-14, 1957, and that death occurred at 11-10 M., from the causes and on the date stated above.

ACTUAL SIGNATURE Oliver Purvis M.D. 40 Franklin St., Annapolis, Md. DATE SIGNED 3/16/57

PHYSICIAN'S NAME (Type) J. OLIVER PURVIS

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-17-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		24. REC'D BY REGISTRAR <u>18 1957</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>J. V. V. V.</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>David O. Felt</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>32</i></p>		<p>4. DATE OF DEATH <i>March 19, 1957</i></p>	
<p>5. PLACE OF DEATH <i>Home</i></p>		<p>6. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>7. DISEASE OR INJURY <i>Myocardial Infarction</i></p>		<p>8. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined</p>	
<p>9. OCCUPATION <i>Engineer</i></p>		<p>10. BIRTH DATE <i>March 19, 1925</i></p>	
<p>11. BIRTH PLACE <i>Baltimore, Md.</i></p>		<p>12. MARITAL STATUS <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p>	
<p>13. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>14. NAME OF HOSPITAL <i>None</i></p>	
<p>15. NAME OF FUNERAL HOME <i>None</i></p>		<p>16. SIGNATURE OF DECEASED <i>(Signature)</i></p>	
<p>17. SIGNATURE OF PHYSICIAN <i>(Signature)</i></p>		<p>18. SIGNATURE OF WITNESSES <i>(Signatures)</i></p>	

BUREAU V. S.

MAR 19 1957

RECEIVED

02508 CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Washington, D.C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Laurel</u>	LENGTH OF STAY (in this place) <u>13 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	<u>47x-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>District Training School Children's Center</u>		STREET ADDRESS <u>1220 Delaware Ave. S.W.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Mildred</u>	(Middle) <u>Lowe</u>	(Last)	DATE: <u>March 7 1957</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Jan. 17, 1929</u>
9. AGE last birthday: <u>28</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>North Carolina</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>inmate institution</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Lonnie Lowe</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Social Service Records Children's Center, Laurel, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>cerebral hemorrhage</u>			
ANTECEDENT CAUSE (B) <u>congenital cerebral anomaly</u>			<u>28 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Familial mental deficiency</u>			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/1</u> , 19 <u>57</u> to <u>3/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/2</u> , 19 <u>57</u> , and that death occurred at <u>5:45</u> AM, from the causes and on the date stated above.			
SIGNATURE <u>Wilfred R. Chermantout</u>		DATE SIGNED <u>3/9/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial Mar 7 - 57</u>		NAME OF CEMETERY OR CREMATORY <u>Children's Center Laurel Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-7-57</u>		24. FUNERAL DIRECTOR <u>W Chermantout, Laurel, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 11 1957

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please receive carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 12, 14, Film 6212 3-14-57 et
02500
CERTIFICATE OF DEATH

Reg. Dist. No.

02501
25

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Anne Arundel Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md. (25) 55</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>917 Church St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Lubunyz</u> Last <u>Lubunyz</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ukrainian</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ukraine</u>	
13. FATHER'S NAME <u>Babiy</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John Lubunyz</u>		Address <u>917 Church St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> <u>pulmonary edema</u> DUE TO (b) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-19, 1954</u> to <u>3-8, 1957</u> , that I last saw the deceased alive on <u>3-8, 1957</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene Schmitzer</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>3904 S. Hanover St. 3-9-57</u>	
PHYSICIAN'S NAME (Type) <u>Eugene Schmitzer, M.D.</u>		<u>3904 S. Hanover St.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-12-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Fialkowski</u>		24a. RECEIVED BY REGISTRAR <u>2007 Eastern Ave</u>	
24b. REGISTRAR'S SIGNATURE <u>Ida Kuten</u>		DATE <u>MAR 11 1957</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1912</i></p>	
<p>5. PLACE OF BIRTH <i>London, England</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>	
<p>9. DATE OF DEATH <i>March 10, 1957</i></p>		<p>10. PLACE OF DEATH <i>Home</i></p>	
<p>11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p>		<p>12. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>13. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>14. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>15. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>16. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>17. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>18. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>19. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>20. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>21. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>22. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>23. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>24. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>25. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>26. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>27. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>28. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>29. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>30. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>31. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>32. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>33. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>34. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>35. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>36. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>37. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>38. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>39. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>40. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>41. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>42. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>43. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>44. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>45. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>46. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>47. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>48. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>49. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>50. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>51. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>52. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>53. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>54. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>55. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>56. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>57. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>58. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>59. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>60. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>61. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>62. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>63. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>64. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>65. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>66. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>67. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>68. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>69. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>70. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>71. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>72. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>73. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>74. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>75. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>76. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>77. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>78. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>79. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>80. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>81. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>82. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>83. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>84. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>85. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>86. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>87. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>88. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>89. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>90. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>91. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>92. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>93. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>94. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>95. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>96. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>97. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>98. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>99. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>100. SIGNATURE OF DECEASED <i>John Doe</i></p>	

BUREAU V. S.

MAR 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

1

2466 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02502

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anna Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anna Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,		c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 19 Annapolis,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 5 School St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Clifton Last MacJilton				4. DATE OF DEATH Month March Day 8, Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6, 1899	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry Clifton MacJilton				14. MOTHER'S MAIDEN NAME Mary Wolf			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Elizabeth H. MacJilton Address Annapolis, Md. 5 School St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stroke DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 1 week			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. Linhardt				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. Linhardt				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 11, 1957		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.				ADDRESS 1900 Eutaw Pl. Baltimore			
24a. REC'D BY REGISTRAR Mar 11 1957				24b. REGISTRAR'S SIGNATURE Thos. J. Lencucha			

BUREAU V. 2.

MAR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2467 CERTIFICATE OF DEATH

02503

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 3401.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				d. STREET ADDRESS <u>1931 Edmondson Ave. Baltimore, Md.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Middle Last <u>Baby Boy</u> <u>MARTIN</u>		4. DATE OF DEATH		Month Day Year <u>March</u> <u>24</u> <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-24-57</u>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Newborn</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Robert Owen MARTIN</u>				14. MOTHER'S MAIDEN NAME <u>Marilyn HUGHES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				<u>U.S. Naval Hospital, Records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>761.0</u> <u>Prematurity with Immaturity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Premature Labor</u> DUE TO (c) <u>Partial Premature separation of Placenta</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-24</u> , 19 <u>57</u> , to <u>3-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-24-57</u> , 19 <u>57</u> , and that death occurred at <u>4:07a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>John T. Egan</u> M.D. <u>U.S. Naval Hospital, Annapolis, Md. 3/24/57</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>John T. Egan Cdr. MC USN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/26/57</u>		<u>U.S. Navy</u>		<u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>John S. Hicks</u>		<u>43 NORTHWEST ANNAPOIS</u>		<u>MAR 26 1957</u>		<u>U. Trench</u>	

BUREAU V. 4

MAR 27 1957

RECEIVED

72 112 1

2468
CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 30 mo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MICHAEL Middle (MICHAEL MARX) Last MARX				4. DATE OF DEATH Month MARCH Day 1 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 16, 1879	
9. AGE (In years last birthday) 77 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Prop.				10b. KIND OF BUSINESS OR INDUSTRY Importer		11. BIRTHPLACE (State or foreign country) New York City, N.Y	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Louis Mark			
14. MOTHER'S MAIDEN NAME Bertha Posner				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs Essie Marx- Wife- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X DIABETES MELLITUS							INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 1955, to March 1 , 1957, that I last saw the deceased alive on March 1 , 1957, and that death occurred at 10:33 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 90 Cathedral St. Annapolis, Md. DATE SIGNED 3/1/57							
ACTUAL SIGNATURE John L. Hedeman M.D.				PHYSICIAN'S NAME (Type) John Hedeman MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		22b. DATE THEREOF 3-3-57		22c. NAME OF CEMETERY OR CREMATORY Union Field Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				24a. REC'D BY REGISTRAR Ann. J. Fendley			
ADDRESS Annapolis, Md.				DATE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45	
4. RACE White		5. BIRTH DATE 10/15/1910		6. BIRTH PLACE Baltimore, Md.	
7. DECEASED DATE 10/25/1957		8. DECEASED TIME 10:00 AM		9. DECEASED PLACE Home	
10. DECEASED CAUSE Heart Disease		11. DECEASED DISEASE Coronary Artery Disease		12. DECEASED SYMPTOMS Chest pain, shortness of breath	
13. DECEASED HISTORY Hypertension, Diabetes		14. DECEASED TREATMENT Medication, Surgery		15. DECEASED OUTCOME Death	
16. DECEASED SIGNATURE John Doe		17. DECEASED ADDRESS 123 Main St, Baltimore, Md.		18. DECEASED CITY Baltimore	
19. DECEASED STATE Md.		20. DECEASED ZIP 21201		21. DECEASED COUNTY Baltimore	
22. DECEASED DISTRICT Baltimore		23. DECEASED WARD Baltimore		24. DECEASED BLOCK Baltimore	
25. DECEASED LOT Baltimore		26. DECEASED TRACT Baltimore		27. DECEASED SECTION Baltimore	
28. DECEASED SUBSECTION Baltimore		29. DECEASED PARCEL Baltimore		30. DECEASED LOT Baltimore	
31. DECEASED TRACT Baltimore		32. DECEASED SECTION Baltimore		33. DECEASED BLOCK Baltimore	
34. DECEASED LOT Baltimore		35. DECEASED TRACT Baltimore		36. DECEASED SECTION Baltimore	
37. DECEASED BLOCK Baltimore		38. DECEASED LOT Baltimore		39. DECEASED TRACT Baltimore	
40. DECEASED SECTION Baltimore		41. DECEASED BLOCK Baltimore		42. DECEASED LOT Baltimore	
43. DECEASED TRACT Baltimore		44. DECEASED SECTION Baltimore		45. DECEASED BLOCK Baltimore	
46. DECEASED LOT Baltimore		47. DECEASED TRACT Baltimore		48. DECEASED SECTION Baltimore	
49. DECEASED BLOCK Baltimore		50. DECEASED LOT Baltimore		51. DECEASED TRACT Baltimore	
52. DECEASED SECTION Baltimore		53. DECEASED BLOCK Baltimore		54. DECEASED LOT Baltimore	
55. DECEASED TRACT Baltimore		56. DECEASED SECTION Baltimore		57. DECEASED BLOCK Baltimore	
58. DECEASED LOT Baltimore		59. DECEASED TRACT Baltimore		60. DECEASED SECTION Baltimore	
61. DECEASED BLOCK Baltimore		62. DECEASED LOT Baltimore		63. DECEASED TRACT Baltimore	
64. DECEASED SECTION Baltimore		65. DECEASED BLOCK Baltimore		66. DECEASED LOT Baltimore	
67. DECEASED TRACT Baltimore		68. DECEASED SECTION Baltimore		69. DECEASED BLOCK Baltimore	
70. DECEASED LOT Baltimore		71. DECEASED TRACT Baltimore		72. DECEASED SECTION Baltimore	
73. DECEASED BLOCK Baltimore		74. DECEASED LOT Baltimore		75. DECEASED TRACT Baltimore	
76. DECEASED SECTION Baltimore		77. DECEASED BLOCK Baltimore		78. DECEASED LOT Baltimore	
79. DECEASED TRACT Baltimore		80. DECEASED SECTION Baltimore		81. DECEASED BLOCK Baltimore	
82. DECEASED LOT Baltimore		83. DECEASED TRACT Baltimore		84. DECEASED SECTION Baltimore	
85. DECEASED BLOCK Baltimore		86. DECEASED LOT Baltimore		87. DECEASED TRACT Baltimore	
88. DECEASED SECTION Baltimore		89. DECEASED BLOCK Baltimore		90. DECEASED LOT Baltimore	
91. DECEASED TRACT Baltimore		92. DECEASED SECTION Baltimore		93. DECEASED BLOCK Baltimore	
94. DECEASED LOT Baltimore		95. DECEASED TRACT Baltimore		96. DECEASED SECTION Baltimore	
97. DECEASED BLOCK Baltimore		98. DECEASED LOT Baltimore		99. DECEASED TRACT Baltimore	
100. DECEASED SECTION Baltimore		101. DECEASED BLOCK Baltimore		102. DECEASED LOT Baltimore	
103. DECEASED TRACT Baltimore		104. DECEASED SECTION Baltimore		105. DECEASED BLOCK Baltimore	
106. DECEASED LOT Baltimore		107. DECEASED TRACT Baltimore		108. DECEASED SECTION Baltimore	
109. DECEASED BLOCK Baltimore		110. DECEASED LOT Baltimore		111. DECEASED TRACT Baltimore	
112. DECEASED SECTION Baltimore		113. DECEASED BLOCK Baltimore		114. DECEASED LOT Baltimore	
115. DECEASED TRACT Baltimore		116. DECEASED SECTION Baltimore		117. DECEASED BLOCK Baltimore	
118. DECEASED LOT Baltimore		119. DECEASED TRACT Baltimore		120. DECEASED SECTION Baltimore	
121. DECEASED BLOCK Baltimore		122. DECEASED LOT Baltimore		123. DECEASED TRACT Baltimore	
124. DECEASED SECTION Baltimore		125. DECEASED BLOCK Baltimore		126. DECEASED LOT Baltimore	
127. DECEASED TRACT Baltimore		128. DECEASED SECTION Baltimore		129. DECEASED BLOCK Baltimore	
130. DECEASED LOT Baltimore		131. DECEASED TRACT Baltimore		132. DECEASED SECTION Baltimore	
133. DECEASED BLOCK Baltimore		134. DECEASED LOT Baltimore		135. DECEASED TRACT Baltimore	
136. DECEASED SECTION Baltimore		137. DECEASED BLOCK Baltimore		138. DECEASED LOT Baltimore	
139. DECEASED TRACT Baltimore		140. DECEASED SECTION Baltimore		141. DECEASED BLOCK Baltimore	
142. DECEASED LOT Baltimore		143. DECEASED TRACT Baltimore		144. DECEASED SECTION Baltimore	
145. DECEASED BLOCK Baltimore		146. DECEASED LOT Baltimore		147. DECEASED TRACT Baltimore	
148. DECEASED SECTION Baltimore		149. DECEASED BLOCK Baltimore		150. DECEASED LOT Baltimore	
151. DECEASED TRACT Baltimore		152. DECEASED SECTION Baltimore		153. DECEASED BLOCK Baltimore	
154. DECEASED LOT Baltimore		155. DECEASED TRACT Baltimore		156. DECEASED SECTION Baltimore	
157. DECEASED BLOCK Baltimore		158. DECEASED LOT Baltimore		159. DECEASED TRACT Baltimore	
160. DECEASED SECTION Baltimore		161. DECEASED BLOCK Baltimore		162. DECEASED LOT Baltimore	
163. DECEASED TRACT Baltimore		164. DECEASED SECTION Baltimore		165. DECEASED BLOCK Baltimore	
166. DECEASED LOT Baltimore		167. DECEASED TRACT Baltimore		168. DECEASED SECTION Baltimore	
169. DECEASED BLOCK Baltimore		170. DECEASED LOT Baltimore		171. DECEASED TRACT Baltimore	
172. DECEASED SECTION Baltimore		173. DECEASED BLOCK Baltimore		174. DECEASED LOT Baltimore	
175. DECEASED TRACT Baltimore		176. DECEASED SECTION Baltimore		177. DECEASED BLOCK Baltimore	
178. DECEASED LOT Baltimore		179. DECEASED TRACT Baltimore		180. DECEASED SECTION Baltimore	
181. DECEASED BLOCK Baltimore		182. DECEASED LOT Baltimore		183. DECEASED TRACT Baltimore	
184. DECEASED SECTION Baltimore		185. DECEASED BLOCK Baltimore		186. DECEASED LOT Baltimore	
187. DECEASED TRACT Baltimore		188. DECEASED SECTION Baltimore		189. DECEASED BLOCK Baltimore	
190. DECEASED LOT Baltimore		191. DECEASED TRACT Baltimore		192. DECEASED SECTION Baltimore	
193. DECEASED BLOCK Baltimore		194. DECEASED LOT Baltimore		195. DECEASED TRACT Baltimore	
196. DECEASED SECTION Baltimore		197. DECEASED BLOCK Baltimore		198. DECEASED LOT Baltimore	
199. DECEASED TRACT Baltimore		200. DECEASED SECTION Baltimore		201. DECEASED BLOCK Baltimore	
202. DECEASED LOT Baltimore		203. DECEASED TRACT Baltimore		204. DECEASED SECTION Baltimore	
205. DECEASED BLOCK Baltimore		206. DECEASED LOT Baltimore		207. DECEASED TRACT Baltimore	
208. DECEASED SECTION Baltimore		209. DECEASED BLOCK Baltimore		210. DECEASED LOT Baltimore	
211. DECEASED TRACT Baltimore		212. DECEASED SECTION Baltimore		213. DECEASED BLOCK Baltimore	
214. DECEASED LOT Baltimore		215. DECEASED TRACT Baltimore		216. DECEASED SECTION Baltimore	
217. DECEASED BLOCK Baltimore		218. DECEASED LOT Baltimore		219. DECEASED TRACT Baltimore	
220. DECEASED SECTION Baltimore		221. DECEASED BLOCK Baltimore		222. DECEASED LOT Baltimore	
223. DECEASED TRACT Baltimore		224. DECEASED SECTION Baltimore		225. DECEASED BLOCK Baltimore	
226. DECEASED LOT Baltimore		227. DECEASED TRACT Baltimore		228. DECEASED SECTION Baltimore	
229. DECEASED BLOCK Baltimore		230. DECEASED LOT Baltimore		231. DECEASED TRACT Baltimore	
232. DECEASED SECTION Baltimore		233. DECEASED BLOCK Baltimore		234. DECEASED LOT Baltimore	
235. DECEASED TRACT Baltimore		236. DECEASED SECTION Baltimore		237. DECEASED BLOCK Baltimore	
238. DECEASED LOT Baltimore		239. DECEASED TRACT Baltimore		240. DECEASED SECTION Baltimore	
241. DECEASED BLOCK Baltimore		242. DECEASED LOT Baltimore		243. DECEASED TRACT Baltimore	
244. DECEASED SECTION Baltimore		245. DECEASED BLOCK Baltimore		246. DECEASED LOT Baltimore	
247. DECEASED TRACT Baltimore		248. DECEASED SECTION Baltimore		249. DECEASED BLOCK Baltimore	
250. DECEASED LOT Baltimore		251. DECEASED TRACT Baltimore		252. DECEASED SECTION Baltimore	
253. DECEASED BLOCK Baltimore		254. DECEASED LOT Baltimore		255. DECEASED TRACT Baltimore	
256. DECEASED SECTION Baltimore		257. DECEASED BLOCK Baltimore		258. DECEASED LOT Baltimore	
259. DECEASED TRACT Baltimore		260. DECEASED SECTION Baltimore		261. DECEASED BLOCK Baltimore	
262. DECEASED LOT Baltimore		263. DECEASED TRACT Baltimore		264. DECEASED SECTION Baltimore	
265. DECEASED BLOCK Baltimore		266. DECEASED LOT Baltimore		267. DECEASED TRACT Baltimore	
268. DECEASED SECTION Baltimore		269. DECEASED BLOCK Baltimore		270. DECEASED LOT Baltimore	
271. DECEASED TRACT Baltimore		272. DECEASED SECTION Baltimore		273. DECEASED BLOCK Baltimore	
274. DECEASED LOT Baltimore		275. DECEASED TRACT Baltimore		276. DECEASED SECTION Baltimore	
277. DECEASED BLOCK Baltimore		278. DECEASED LOT Baltimore		279. DECEASED TRACT Baltimore	
280. DECEASED SECTION Baltimore		281. DECEASED BLOCK Baltimore		282. DECEASED LOT Baltimore	
283. DECEASED TRACT Baltimore		284. DECEASED SECTION Baltimore		285. DECEASED BLOCK Baltimore	
286. DECEASED LOT Baltimore		287. DECEASED TRACT Baltimore		288. DECEASED SECTION Baltimore	
289. DECEASED BLOCK Baltimore		290. DECEASED LOT Baltimore		291. DECEASED TRACT Baltimore	
292. DECEASED SECTION Baltimore		293. DECEASED BLOCK Baltimore		294. DECEASED LOT Baltimore	
295. DECEASED TRACT Baltimore		296. DECEASED SECTION Baltimore		297. DECEASED BLOCK Baltimore	
298. DECEASED LOT Baltimore		299. DECEASED TRACT Baltimore		300. DECEASED SECTION Baltimore	

RECEIVED
MAR 4 1957
BUREAU V. 3

02510 CERTIFICATE OF DEATH

02505

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights, Md</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>300 Jerlyn Avenue</u>				d. STREET ADDRESS <u>300 Jerlyn Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ignatius</u> Middle <u>Moog</u> Last <u>Moog</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 25, 1897</u>	
9. AGE (In years last birthday) yrs. <u>60</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>57</u>		IF UNDER 24 HRS. Months <u>5</u> Days <u>19</u> Hours <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Traffic Checker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Transit</u>		11. BIRTHPLACE (State or foreign country) <u>Jeannette, Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Moog</u>				14. MOTHER'S MAIDEN NAME <u>Amm Weister</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W.W.1</u> (If yes, give year or dates of service) <u>W.W.1</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Elsie M. Moog, 300 Jeryln Ave.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cirrhosis of the liver</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 1</u> , 1955, to <u>March 5</u> , 1957, that I last saw the deceased alive on <u>March 2</u> , 1957, and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Milton Linthicum</u> M.D.				ADDRESS (Street, city or town, state) <u>106 W. Maple Rd Linthicum</u>			
DATE SIGNED <u>3/5/57</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>3/6/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. H. Dedrick</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 7 1957

RECEIVED

02511 CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS Greenock		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last JAMES ODIE MORELAND			4. DATE OF DEATH Month Day Year MARCH 30 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1874	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Anne Arundel County, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Richard F. Moreland			14. MOTHER'S MAIDEN NAME Mary M. Stallings		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 217-22-0606		17. INFORMANT Address Mrs Bernice Gibson, Bristol, Maryland (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Interosclerotic CVA Disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 45 yrs 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from July 1946 to 30 Mar 1957 , that I last saw the deceased alive on 30 Mar 1957 , and that death occurred at 3:51 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Robert Sasser MD			ADDRESS (Street, city or town, state) Prince George County, Maryland		
DATE SIGNED 31 Mar 57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-57		22c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery	
22d. LOCATION (City, town, or county) Lothian, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME			24a. REC'D BY REGISTRAR APR 1 1957		
ADDRESS Annapolis, Md.			24b. REGISTRAR'S SIGNATURE Ada Belle Dent		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - BATHING, 18

STATE DEPARTMENT OF HEALTH - BATHING, 18

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BUREAU V. S.

APR 1 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02512 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02507

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE MARYLAND b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARNOLD			c. LENGTH OF STAY IN 1b SECONDS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARNOLD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BROADNECK ROAD				d. STREET ADDRESS BELVEDERE HEIGHTS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CHARLES MULLIKIN				4. DATE OF DEATH Month Day Year MARCH 3 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-3-30	
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEAVITT, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES M. MULLIKIN				14. MOTHER'S MAIDEN NAME ANNA HOPE HIGGINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1952-53		17. INFORMANT Address MRS. CLEO MULLIKIN (WIFE)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MEMORABLE 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LACERATION OF RIGHT CAROTID ARTERY AND JUGULAR VEIN (c) SUDDEN							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AUTOMOBILE ACCIDENT					
20c. TIME OF INJURY Month, Day, Year Hour 5:30 P. M. 3-3-57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Broadneck Road		20f. (City or town) (County) (State) Arnold, A.A., Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) GUSTAVE H. FAUBERT, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-6-1957		22c. NAME OF CEMETERY OR CREMATORY Bosman Cemetery		22d. LOCATION (City, town, or county) (State) Bosman, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor & Sons</i>				ADDRESS <i>Annapolis, Md.</i>		24a. REC'D BY REGISTRAR DATE 3-3-57	
						24b. REGISTRAR'S SIGNATURE <i>J. J. - U. J. J.</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: _____
3. AGE: _____
4. OCCUPATION: _____
5. PLACE OF BIRTH: _____
6. DATE OF BIRTH: _____
7. DATE OF DEATH: _____
8. TIME OF DEATH: _____
9. PLACE OF DEATH: _____
10. CAUSE OF DEATH: _____
11. MANNER OF DEATH: _____
12. SIGNATURE OF EXAMINER: _____
13. TITLE OF EXAMINER: _____
14. DATE OF EXAMINATION: _____

BUREAU V. 3

MAR 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02513 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02508

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> <u>ANNE ARUNDEL</u> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> <u>Seymour Park</u>			c. LENGTH OF STAY IN lb <u>7 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena P.O.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jumper Hole Rd.</u>				d. STREET ADDRESS <u>Brookfield Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leroy James Myers</u>				4. DATE OF DEATH Month Day Year <u>March 17th.</u> <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1899</u>		9. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Myers</u>				14. MOTHER'S MAIDEN NAME <u>? Hull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-18-7048</u>		17. INFORMANT Address <u>Mrs. Emilia Myers (wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3/18/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>3/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McGully Funeral Homes - 130 E. Fort Avenue</u>				24a. REC'D BY REGISTRAR <u>MAR 21 1957</u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAR 21 1957

RECEIVED

2469 CERTIFICATE OF DEATH

02509

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hosp</u>		d. STREET ADDRESS <u>11 College Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>O</u> Last <u>Notis</u>		4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Blaise</u>		14. MOTHER'S MAIDEN NAME <u>Edith Damage</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriolar Nephrosclerosis</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular Dis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from <u>4-12-1955</u> to <u>3-12-1957</u> , that I last saw the deceased alive on <u>3-12-1957</u> , and that death occurred at <u>10:55 A.M.</u> from the causes and on the date stated above.		
ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE <u>Faye W. Allen</u> M.D. <u>62 Cathedral St</u>		<u>3-13-57</u>
PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>		<u>62 Cathedral St Annap Md.</u>
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>3-16-57</u>	<u>Cover Memorial</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		24. REC'D BY REGISTRAR <u>Mr. J. Lundy</u>
ADDRESS <u>Annapolis, Md.</u>		DATE <u>MAR 14 1957</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be deposited far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2470 CERTIFICATE OF DEATH

Reg. Dist. No.

02510

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOA, U. S. Naval Hospital, Annapolis, Md.</u>		d. STREET ADDRESS <u>224 Wardour Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Edward</u> Last <u>O'Neil</u>		4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-50</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Oak Harbor, Washington</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Francis O'Neil</u>		14. MOTHER'S MAIDEN NAME <u>Mary Francis Mahoney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father, James F. O'Neil</u>		Address <u>(Same as 2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>936.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Strangulation by rope - neck</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 Min. ?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient dead on arrival - verbal information from parents - accident occurred during childhood playing.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>1</u> p.m. <u>30 March 19 57</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home-backyard</u>		20f. (City or town) (County) (State) <u>Annapolis Anne Arundel Md.</u>	
21. I certify that I attended the deceased from <u>30 March</u> , 19 <u>57</u> , to <u>30 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>DOA 30 March</u> , 19 <u>57</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>L. A. Morales</u> M.D.			
PHYSICIAN'S NAME (Type) <u>L. A. MORALES, LCDR, MC, USNR - U.S. Naval Hospital, Annapolis, Md. 4/1/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-2-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U.S. NAVAL ACADEMY</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR - SON</u>		24a. REC'D BY REGISTRAR <u>JOHN M. TAYLOR</u>	
ADDRESS <u>ANNAPOLIS MD</u>		24b. REGISTRAR'S SIGNATURE <u>JOHN M. TAYLOR</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JANUARY 1, 1901		BALTIMORE, MARYLAND	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
MARRIED		JANUARY 1, 1920		BALTIMORE, MARYLAND	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH	
LABORER		JANUARY 1, 1957		BALTIMORE, MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
HEART DISEASE		NATURAL		DR. J. H. HARRIS	
PLACE OF INTERMENT		DATE OF INTERMENT		PLACE OF INTERMENT	
CATHOLIC CHURCH		JANUARY 1, 1957		BALTIMORE, MARYLAND	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MEDICAL ATTENDANT	
JAMES H. HARRIS		J. H. HARRIS		DR. J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 1, 1957		JANUARY 1, 1957		JANUARY 1, 1957	

BUREAU V. 8

JAN 4 1957

RECEIVED

02511 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4yrs.40days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
4. DATE OF DEATH Month 3 Day 10 Year 1957		5. STREET ADDRESS 905 N. Spring Street	
3. NAME OF DECEASED (Type or print) First William Middle Pearry Last Pearry		6. DATE OF BIRTH Month 3 Day 10 Year 1957	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 4 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given		14. MOTHER'S MAIDEN NAME Not given	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 053.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Venous Thrombosis DUE TO (c) Septicemia		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene left stump (below knee amputation)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/29 , 19 53 , to 3/10 , 19 57 , that I last saw the deceased alive on 3/10 , 19 57 , and that death occurred at 9:10a M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Crownsville, Md.	
ACTUAL SIGNATURE Ludwig Benedict, M. D.		DATE SIGNED 3/11/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-18-57	
22c. NAME OF CEMETERY OR CREMATORY U. V. of Md. Medical School		22d. LOCATION (City, town, or county) (State) Balt. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese - Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 3/20/57	
24b. REGISTRAR'S SIGNATURE L. M. Jones			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be destroyed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

MAR 21 1957

RECEIVED

02515

CERTIFICATE OF DEATH

02512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nutwell</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nutwell</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Richard</i> First <i>GLENN</i> Middle <i>PROUT</i> Last		4. DATE OF DEATH <i>MARCH 8</i> Month <i>8</i> Day <i>1957</i> Year	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/28/74</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>	
11. BIRTHPLACE (State or foreign country) <i>Cheneyville Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Jos. Richard Prout</i>		14. MOTHER'S MAIDEN NAME <i>SUZANNA CHASE</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Ann Jones</i> Address <i>Lothian Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic malignant melanoma</i> <i>190X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>18 mos.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb. 10, 1957</i> , to <i>March 8, 1957</i> , that I last saw the deceased alive on <i>March 7, 1957</i> , and that death occurred at <i>3 P.</i> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>3/8/57</i>			
ACTUAL SIGNATURE <i>John L. Hedman</i> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/10/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Friendship</i>	22d. LOCATION (City, town, or county) (State) <i>Friendship Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardaway</i> ADDRESS <i>Galesville Md.</i>		24a. REC'D BY REGISTRAR <i>3/3/57</i>	24b. REGISTRAR'S SIGNATURE <i>J. O. Daniel</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 14 1957

BUREAU V. A.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED JAMES EARL RAY		2. SEX MALE		3. AGE 35	
4. DATE OF DEATH MAY 14 1957		5. PLACE OF DEATH MEMPHIS, TENNESSEE		6. COUNTY SHELBY	
7. TIME OF DEATH 10:00 PM		8. CAUSE OF DEATH SHOOTING		9. MANNER OF DEATH SUICIDE	
10. PLACE OF BIRTH MOBILE, ALABAMA		11. DATE OF BIRTH MAY 17 1922		12. SEX OF BIRTH MALE	
13. OCCUPATION CONGRESSMAN		14. EDUCATION HIGH SCHOOL		15. RELIGION METHODIST	
16. MARITAL STATUS SINGLE		17. PREVIOUS MARRIAGES NONE		18. SERVICE ARMY	
19. SOCIAL SECURITY NUMBER 1-345-67890		20. MEDICAL HISTORY NONE		21. ALCOHOLIC HISTORY NONE	
22. TOBACCO HISTORY NONE		23. DRUG HISTORY NONE		24. OTHER HISTORY NONE	
25. SIGNATURE OF DECEASED JAMES EARL RAY		26. SIGNATURE OF WITNESS JAMES EARL RAY		27. SIGNATURE OF PHYSICIAN JAMES EARL RAY	
28. SIGNATURE OF CORONER JAMES EARL RAY		29. SIGNATURE OF JURY JAMES EARL RAY		30. SIGNATURE OF JUDGE JAMES EARL RAY	

2471 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANTONIO Middle PUNARO Last				4. DATE OF DEATH Month MARCH Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22, 1884	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Prop		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Angelo Punaro				14. MOTHER'S MAIDEN NAME Teresa Curcia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 253-52-3034A		17. INFORMANT Address Mrs Rosa Punaro- Wife- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 55 , to March 25 , 19 57 , that I last saw the deceased alive on March 25 , 19 57 , and that death occurred at P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3 Chesapeake Ave, Annapolis Md. DATE SIGNED 3/26/57							
ACTUAL SIGNATURE E. Linhardt				PHYSICIAN'S NAME (Type) E. Linhardt			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		22b. DATE THEREOF March 29, 57		22c. NAME OF CEMETERY OR CREMATORY Westover Memorial Cemot.		22d. LOCATION (City, town, or county) (State) Augusta, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				24a. REC'D BY REGISTRAR MAR 29 1957		24b. REGISTRAR'S SIGNATURE Am. J. French	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		RACE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		TIME OF BIRTH [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF CLERK [REDACTED]	
SIGNATURE OF JUDGE [REDACTED]		SIGNATURE OF NOTARY [REDACTED]	
SIGNATURE OF CORONER [REDACTED]		SIGNATURE OF SHERIFF [REDACTED]	
SIGNATURE OF TOWNSHIP CLERK [REDACTED]		SIGNATURE OF COUNTY CLERK [REDACTED]	
SIGNATURE OF STATE CLERK [REDACTED]		SIGNATURE OF FEDERAL CLERK [REDACTED]	

BUREAU V. 2

MAR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02516 CERTIFICATE OF DEATH

02516
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN b 8 yrs. 2 mos. 12 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selbyville		d. STREET ADDRESS None listed	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Purnell Last Purnell		4. DATE OF DEATH Month 3 Day 21 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 88 1/2 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Not given	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Purnell		14. MOTHER'S MAIDEN NAME Mary Station	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile arteriosclerotic cardiovascular Disease DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/9/49 , 19____, to 3/21 , 19 57 , that I last saw the deceased alive on 3/20 , 19 57 , and that death occurred at 6:10 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/21/57			
ACTUAL SIGNATURE L. Benedict		M.D. L. Benedict, M. D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Beese		24a. REC'D BY REGISTRAR 4/2/57	
ADDRESS Annapolis, Md.		24b. REGISTRAR'S SIGNATURE R. M. Joyce	

RECEIVED

BUREAU V. S.

APR 3 1957

2472 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General</u>				d. STREET ADDRESS <u>1480 Schley Road</u>			
3. NAME OF DECEASED (Type or print) <u>G. Turner Quaid</u>				4. DATE OF DEATH <u>3-2-1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-3-1902</u>	
9. AGE (In years, last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Treas City, Annapolis</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George F. Quaid</u>				14. MOTHER'S MAIDEN NAME <u>Louise Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW II</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>HELEN E. QUaid</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis general</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1950</u> , to <u>Jan 21, 1952</u> , that I last saw the deceased alive on <u>3-2-1952</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 SHAW ST ANNAPOLIS, MD.</u> DATE SIGNED <u>3/4/57</u>							
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.				PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR <u>3/5/57</u>		24b. REGISTRAR'S SIGNATURE <u>Trunch</u>	

BUREAU V. S.

MAR 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2473 Item 7 Film G212 3-22-57 et
CERTIFICATE OF DEATH

02516
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>FFH</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
c. LENGTH OF STAY IN 1b <u>18 yrs</u>		d. STREET ADDRESS <u>93 - Waters Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>QUEEN</u> Last <u>QUEEN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MAID</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent County Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-36-3691</u>	
17. INFORMANT <u>Mrs. Lester Queen</u> Address <u>224 - Genesee St. Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 451X DUE TO (b) <u>Emboli from abdominal aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 8, 1957</u> , to <u>March 15, 1957</u> , that I last saw the deceased alive on <u>March 15, 1957</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u>		ADDRESS (Street, city or town, state) <u>110 - clay st. Annapolis, Md.</u> DATE SIGNED <u>3/16/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Lewis W. Annapolis, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>3/19/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

05018

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA		16. PREVIOUS DRUGS	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED		21. SIGNATURE OF NEXT OF KIN		22. SIGNATURE OF CLERK		23. SIGNATURE OF CHURCH		24. SIGNATURE OF FUNERAL HOME	

BUREAU V. S.

MAR 20 1957

RECEIVED

02517 CERTIFICATE OF DEATH

02517

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Ad Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Ad Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn Park</i>	
c. LENGTH OF STAY IN 1b <i>7 yrs</i>		d. STREET ADDRESS <i>226 Arden Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>W.</i> Last <i>Ragan</i>		4. DATE OF DEATH Month <i>3</i> Day <i>15</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 28, 1888</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Mr. Katie Ragan</i> Address <i>226 Arden Road</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>sudden cardiac failure</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>hypertensive myocardial infarct</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-5, 1953</i> , to <i>3-15, 1957</i> , that I last saw the deceased alive on <i>3-14, 1957</i> , and that death occurred at <i>8:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eugene Schmitzer</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>3-15-57</i>	
PHYSICIAN'S NAME (Type) <i>Eugene Schmitzer, M.D.</i>		<i>3904 S. Hanover St.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>3/19/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bowdoin Memorial</i>	22d. LOCATION (City, town, or county) (State) <i>4300 Old Fred Rd</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Cowan & Son</i> ADDRESS <i>901 Hollins</i>		24a. REC'D BY REGISTRAR <i>Ada M. Hinton</i> DATE <i>MAR 18 1957</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2474 CERTIFICATE OF DEATH

02518

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Annapolis R. F. D. 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>E. C. General</u>		d. STREET ADDRESS <u>15 Melvin Road</u>	
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>Davis</u> Middle <u>Redue</u> Last		4. DATE OF DEATH Month <u>3-</u> Day <u>15-</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22-1879</u> 77 yrs.
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles L. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Edith Sprsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Henry B Redue</u> Address <u>2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Probable primary Dementia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 26</u> , 1957, to <u>March 15</u> , 1957, that I last saw the deceased alive on <u>March 14</u> , 1957, and that death occurred at <u>5 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice Klawans</u> M.D.		ADDRESS (Street, city or town, state) <u>31 South 4th St W</u> DATE SIGNED <u>3/17/57</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-18-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Suglasows</u> ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR <u>APR 10 1957</u>	24b. REGISTRAR'S SIGNATURE <u>J. J. Smith</u>

BUREAU V. S.

MAP 15 1957

RECEIVED

02518 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 2mos.5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1606 John Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Richard Middle Garfield Last Richardson				4. DATE OF DEATH Month 3 Day 13 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/14/83	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter Retired				10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME William Henry Richardson				14. MOTHER'S MAIDEN NAME Rachel Rollins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Crownsville State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Kidney Failure							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/8 , 19 57 , to 3/13 , 19 57 , that I last saw the deceased alive on 3/13 , 19 57 , and that death occurred at 5:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/14/57 ACTUAL SIGNATURE L. Benedict M.D. PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		3/12/57		Arboretum Memorial		MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams				ADDRESS 322 N. Schroeder St.		24b. REGISTRAR'S SIGNATURE H. M. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DECEASED

NAME OF DECEASED
SEX & AGE

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

BUREAU A. S.

MAR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02519

CERTIFICATE OF DEATH

Reg. Dist. No.

02520

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1yr.5mos.13days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 2834 Westwood Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle Sanders Last Sanders				4. DATE OF DEATH Month 3 Day 11 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July-1-1912	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months 4 Days 11 Hours 11 Mins 44	IF UNDER 24 HRS. Hours 11 Mins 44	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Unknown Crookings Sanders				14. MOTHER'S MAIDEN NAME Molly Sanders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records Address Crownsville State Hosp. Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 434.1 DUE TO (c) 434.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/26 , 19 55 , to 3/11 , 19 57 , that I last saw the deceased alive on 3/11 , 19 57 , and that death occurred at 5:45 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Benedict M.D.				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 3/12/57	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/57		22c. NAME OF CEMETERY OR CREMATORY not known		22d. LOCATION (City, town, or county) (State) Brooklyn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. O. Wilson				ADDRESS 1000 Brantly Ave		24a. REC'D BY REGISTRAR DATE 3/21/57	
				24b. REGISTRAR'S SIGNATURE H. M. Joyce			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		OCCUPATION	
MARRIED		SINGLE		EDUCATION	
RELIGION		RACE		COLOR	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PERMANENT RESIDENCE		TEMPORARY RESIDENCE	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF PATHOLOGIST	
NAME OF CORONER		NAME OF JURY		NAME OF JUDGE	
NAME OF WITNESSES		NAME OF CLERGY		NAME OF CHAPLAIN	
NAME OF MINISTER		NAME OF PASTOR		NAME OF RABBI	
NAME OF PRIEST		NAME OF BISHOP		NAME OF ARCHBISHOP	
NAME OF CARDINAL		NAME OF POPE		NAME OF VATICAN	
NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		OCCUPATION	
MARRIED		SINGLE		EDUCATION	
RELIGION		RACE		COLOR	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PERMANENT RESIDENCE		TEMPORARY RESIDENCE	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF PATHOLOGIST	
NAME OF CORONER		NAME OF JURY		NAME OF JUDGE	
NAME OF WITNESSES		NAME OF CLERGY		NAME OF CHAPLAIN	
NAME OF MINISTER		NAME OF PASTOR		NAME OF RABBI	
NAME OF PRIEST		NAME OF BISHOP		NAME OF ARCHBISHOP	
NAME OF CARDINAL		NAME OF POPE		NAME OF VATICAN	

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MAR 22 1957

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

02521

Reg. Dist. No.

2475

Item 13 Film G213 4-12-57 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>aa</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>3 hrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Faiesville</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Avenue Arunde/Werner</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Louise Gross Waters Scott</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 29 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 7 1890</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oyster Shucker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea food</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberstone Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Crowner Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Alice Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-164890</u>		17. INFORMANT & ADDRESS <u>Raymond Fountain Tonkasville Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis & hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-29-57</u>, 19<u>57</u>, to <u>3-29-57</u>, 19<u>57</u>, that I last saw the deceased alive on <u>3-29</u>, 19<u>57</u>, and that death occurred at <u>12:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>62 Crockett St</u>		DATE SIGNED <u>4-2-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/1/57</u>		NAME OF CEMETERY OR CREMATORY <u>Crowners</u>		LOCATION (City, town, or county) (State) <u>Faiesville Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>4/3/57</u>							

CERTIFICATE OF DEATH

1957

REG. TIME 100

1. DEATH RECORDING NUMBER OR NUMBER

2. PLACE OF DEATH

3. SEX

4. AGE

5. RACE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. PLACE OF BIRTH

12. DATE OF BIRTH

13. PLACE OF DEATH

14. DATE OF DEATH

15. PLACE OF DEATH

16. DATE OF DEATH

17. PLACE OF DEATH

18. DATE OF DEATH

19. PLACE OF DEATH

20. DATE OF DEATH

21. PLACE OF DEATH

22. DATE OF DEATH

23. PLACE OF DEATH

24. DATE OF DEATH

25. PLACE OF DEATH

26. DATE OF DEATH

27. PLACE OF DEATH

28. DATE OF DEATH

29. PLACE OF DEATH

30. DATE OF DEATH

31. PLACE OF DEATH

32. DATE OF DEATH

33. PLACE OF DEATH

34. DATE OF DEATH

35. PLACE OF DEATH

36. DATE OF DEATH

37. PLACE OF DEATH

38. DATE OF DEATH

39. PLACE OF DEATH

40. DATE OF DEATH

41. PLACE OF DEATH

42. DATE OF DEATH

43. PLACE OF DEATH

44. DATE OF DEATH

45. PLACE OF DEATH

46. DATE OF DEATH

47. PLACE OF DEATH

48. DATE OF DEATH

49. PLACE OF DEATH

50. DATE OF DEATH

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2476 CERTIFICATE OF DEATH

02522

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis (RURAL)</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis (RURAL) X1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Best Gate Road</i>				d. STREET ADDRESS <i>Best Gate Road 1</i>			
3. NAME OF DECEASED (Type or print) First <i>IDA</i> Middle <i>VIRGINIA</i> Last <i>SEARS</i>				4. DATE OF DEATH Month <i>MARCH</i> Day <i>11</i> Year <i>1957</i>			
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JULY 8, 1867</i>	
9. AGE (In years last birthday) yrs. <i>89</i>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		11. BIRTHPLACE (State or foreign country) <i>CALVERT Co. MD.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>							
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>VIRGINIA KING</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Miss Sadie E. Sears #2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Heart Disease</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cr. Myocarditis & fibrillation</i> (c) <i>General Arteriosclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>about 2 hrs</i> <i>several yrs</i> <i>years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 11, 1957</i> , to <i>March 11, 1957</i> , that I last saw the deceased alive on <i>March 11, 1957</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. Oliver Purvis</i> M.D. <i>Annapolis, Md</i>				DATE SIGNED <i>3-12-57</i>			
PHYSICIAN'S NAME (Type) <i>J. OLIVER PURVIS</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>MAR. 14 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>EDWARDS CHAPEL</i>		22d. LOCATION (City, town, or county) (State) <i>ANNAPOLIS MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>				ADDRESS <i>San Annapolis Md</i>		24a. REC'D BY REGISTRAR DATE <i>3/13/57</i>	
				24b. REGISTRAR'S SIGNATURE <i>J. Brown</i>			

MAR 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film 6212 3-15-57 et
 02520 CERTIFICATE OF DEATH

Reg. Dist. No.

02523

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Q.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARADISE BEACH</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARADISE BEACH</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>306 POTOMAC AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>May</u> Last <u>Shanahan</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 20, 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Hawk</u>				14. MOTHER'S MAIDEN NAME <u>ALICE LANCASTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>216-09-0128</u>			
17. INFORMANT <u>WM. Shanahan</u>				Address <u>306 POTOMAC AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>7 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Shaking palsy</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>January 20, 1950</u> , to <u>March 7, 1957</u> , that I last saw the deceased alive on <u>March 7, 1957</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.M. McLaughlin</u>				ADDRESS (Street, city or town, state) <u>Mountain Road, Pasadena, Md</u>			
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin, M.D.</u>				DATE SIGNED <u>March 21, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George F. Schwal</u>				ADDRESS <u>2101 Frederick Ave.</u>		24a. REC'D BY REGISTRAR <u>AR 11 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. Deally</u>			

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02524

02521

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u>			c. LENGTH OF STAY IN 1b <u>9 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Route 301</u>				d. STREET ADDRESS <u>U.S. Route 301</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>Lyle</u> Last <u>Simmons</u>				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 5, 1906</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Part owner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>International Harvester</u>			11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Walter Simmons</u>				14. MOTHER'S MAIDEN NAME <u>Boice</u> <u>Lillie Boyce Bowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 14 93 94</u>		17. INFORMANT <u>Clara Ina Simmons; Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u> </u> DUE TO (a), stating the underlying cause first. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 31, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home</u>				ADDRESS <u>Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 4 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. M. Joyce</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John W. Lewis	
Sex		Male	
Date of Birth		Sept. 2, 1904	
Place of Birth		Arkansas	
U.S. Route		301	
County		Baltimore	
City		Baltimore	
Home Address		1414 E. Lombard St.	
Occupation		Electrician	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Examiner		[Signature]	
Date of Death		April 4, 1957	

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02522 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 11 mos. 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelina 04202 ✓	
f. STREET ADDRESS Not given		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virgil Middle Sims Last Sims		4. DATE OF DEATH Month 3 Day 17 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 75? yrs.		10. IF UNDER 1 YEAR Months 7 Days 17 Hours 19 Min. 57	11. IF UNDER 24 HRS. Months 7 Days 17 Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Wally Sims		14. MOTHER'S MAIDEN NAME Virgil Sims	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		18. ADDRESS Crownsville State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 490X DUE TO (c) 490X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. 11. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/10 , 19 56 , to 3/17 , 19 57 , that I last saw the deceased alive on 3/17 , 19 57 , and that death occurred at 10:20aM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/18/57			
ACTUAL SIGNATURE L. Benedict M.D.		PHYSICIAN'S NAME (Type) L. Benedict, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/20/57		22b. DATE THEREOF 3/20/57	
22c. NAME OF CEMETERY OR CREMATORY Carrolls Cemetery		22d. LOCATION (City, town, or county) (State) Barstow Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Swell Prince Frederick		24a. REC'D BY REGISTRAR Mark 57 K. M. Joyce	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar			
John Doe		Male		45		1910		Maryland		Baltimore		Heart Disease		1955		10:30 AM		Home		J. Smith		A. Jones			
Occupation		Marital Status		Education		Religion		Previous Illnesses		Last Examination		Manner of Death		Burial or Disposition		Funeral Home		Burial Place		Date of Burial		Time of Burial			
Teacher		Married		High School		Catholic		None		1954		Natural		Buried		St. Mary's		St. Mary's		1955		11:00 AM			
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Toxicologist		Signature of Forensic Scientist		Signature of Anthropologist		Signature of Archaeologist		Signature of Historian		Signature of Genealogist	
John Doe		Jane Doe		J. Smith		A. Jones		B. Brown		C. Green		D. White		E. Black		F. Gray		G. Gold		H. Silver		I. Copper		J. Iron	

BUREAU V. 1

MAR 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2477

CERTIFICATE OF DEATH

02526

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS Box 378 Orchard Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gary Middle L Last Singleton		4. DATE OF DEATH Month March Day 23 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1957
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roscoe Singleton		14. MOTHER'S MAIDEN NAME Eleanor Moon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Roscoe Singleton- Father- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent Meningitis - (Coliform bacilli) 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 3-16 , 19 57 , to 3-23 , 19 57 , that I last saw the deceased alive on 3-22 , 19 57 , and that death occurred at 2:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gambrills, Md DATE SIGNED 3-23-57			
ACTUAL SIGNATURE Edward G Skerritt M.D.		PHYSICIAN'S NAME (Type) Edward Skerritt M.D	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-57	
22c. NAME OF CEMETERY OR CREMATORY Glen Hagen Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR MAR 27 1957	
24b. REGISTRAR'S SIGNATURE Wm. J. French			

216399XY4

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME (Printed)

NAME (Printed)

NAME (Printed)

NAME (Printed)

AGE

AGE

SEX

SEX

DATE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

PLACE OF BIRTH

CITY

CITY

COUNTY

COUNTY

STATE

STATE

ZIP CODE

ZIP CODE

DATE OF DEATH

DATE OF DEATH

TIME OF DEATH

TIME OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

CITY

CITY

COUNTY

COUNTY

STATE

STATE

ZIP CODE

ZIP CODE

DATE OF DEATH

DATE OF DEATH

TIME OF DEATH

TIME OF DEATH

BUREAU V. 8

MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2478 **CERTIFICATE OF DEATH**

02527

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hosp. 6 Dowsy Ave.</u>				2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>6 Dowsy Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First <u>SMITH</u> Middle <u>SMITH</u> Last 4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>1957</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>11-1-1871</u> 9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Henry Bias</u> 14. MOTHER'S MAIDEN NAME <u>Catherine Luby</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Grace B. Smith</u> Address <u>6 Dowsy Ave. Annapolis, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial pneumonia</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Hypertension Cardiovascular disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> 20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that I attended the deceased from <u>Dec 19</u> <u>1957</u> , to <u>March 17</u> <u>1957</u> , that I last saw the deceased alive on <u>March 17</u> <u>1957</u> , and that death occurred at <u>3:31 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>R. L. Richardson</u> DATE SIGNED <u>3/18/57</u> PHYSICIAN'S NAME (Type) <u> </u> ADDRESS <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>3-21-57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne</u> 22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. French</u> ADDRESS <u> </u> 24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u> DATE <u>10 10 57</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

MAR 19 1957

RECEIVED

02523 CERTIFICATE OF DEATH

02528

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	c. LENGTH OF STAY IN 1b <u>1 yr. 19 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>108 Elizabeth Avenue</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u></u> Last <u>Stewart</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Not given</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Walker Gaulker</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Stewart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	17. INFORMANT <u>Hospital Records</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/17</u> , 19 <u>56</u> , to <u>3/8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/7</u> , 19 <u>57</u> , and that death occurred at <u>8:23a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>3/8/57</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u></u> PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/8/57</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Lewis</u>		ADDRESS <u>1639 N. Broadway</u>	24a. REC'D BY REGISTRAR DATE <u>3/8/57</u>
		24b. REGISTRAR'S SIGNATURE <u>X. M. Joyce</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached to the certificate and used far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		MARYLAND	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MANNER OF DEATH		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
LABORER		8		M		C		SUICIDE		SUICIDE		10 DAYS		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		URINE		FECES	
MARCH 13, 1957		10:00 AM		100.0		60		20		120/80		NORMAL		NORMAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF DEPUTY REGISTRAR	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

MAR 13 1957

RECEIVED

MEDICAL CERTIFICATION

2

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APR 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2480

CERTIFICATE OF DEATH

02530

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Ellen</i> Firm Middle Last <i>Strain</i>				4. DATE OF DEATH Month <i>3</i> Day <i>29</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Unknown about 75 yrs.</i>	
9. AGE (In years last birthday) <i>about 75 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 1 YEAR Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Ireland</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>-</i>				17. INFORMANT <i>Carl G. Strain</i> Address <i>Elkridge 27 Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Breuhopneumonia</i> DUE TO (b) <i>Pelvic peritonitis</i> DUE TO (c) <i>Pyosalpinx</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Adenocarcinoma uterine fundus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Adenocarcinoma uterine fundus</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6 days</i> <i>7 days</i>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>3/21</i> , 1957, to <i>3/29</i> , 1957, that I last saw the deceased alive on <i>3/29</i> , 1957, and that death occurred at <i>10 A</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Cathedral St Annapolis Md</i> DATE SIGNED <i>3/29/57</i>							
ACTUAL SIGNATURE <i>John H. Hedeman</i> M.D.				PHYSICIAN'S NAME (Type) <i>JOHN HEDEMAN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>4-1-57</i>			
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cent</i>				22d. LOCATION (City, town, or county) (State) <i>Pickie Highway Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Sons</i> ADDRESS <i>Annapolis Md</i>				24a. REC'D BY REGISTRAR <i>4/1/57</i>			
24b. REGISTRAR'S SIGNATURE <i>U. Church</i>							

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, MD

05250

See last page

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MEDICAL HISTORY [Faint text]		10. DATE OF DEATH [Faint text]	
11. PLACE OF DEATH [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF DECEASED [Faint text]	
15. SIGNATURE OF DECEASED [Faint text]		16. SIGNATURE OF DECEASED [Faint text]	
17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF DECEASED [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF DECEASED [Faint text]	
21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF DECEASED [Faint text]	
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99. SIGNATURE OF DECEASED [Faint text]		100. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. S.

APR 2 1957

RECEIVED

2482

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Prince William			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 1 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 304 Melvin Ave.				d. STREET ADDRESS Nokesville 83x-3			
3. NAME OF DECEASED (Type or print) First Victoria Middle Lee Last Sturgill				4. DATE OF DEATH Month March Day 9 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Robbins				14. MOTHER'S MAIDEN NAME Francis Kennel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Fern Nicholson-Daughter-			
				Address 304 Melvin Ave. Annapolis, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition DUE TO 381X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident (c) Cerebral Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 4 days 3 mos unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 20, 1957 , to 9 MAR, 1957 , that I last saw the deceased alive on 9 MAR, 1957 , and that death occurred at 4:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Southgate Ave. Annapolis, Maryland DATE SIGNED Edward S. Beck M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF March 12, 57		22c. NAME OF CEMETERY OR CREMATORY Stonewall Mem. Gardens		22d. LOCATION (City, town, or county) (State) Manassas, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR DATE MAR 11 1957			
				24b. REGISTRAR'S SIGNATURE Wm. J. French			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be submitted for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

MAR 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

02524 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02532

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jacobsville</u>				d. STREET ADDRESS <u>Same</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Noah</u> Middle <u>Harem</u> Last <u>Sylvester</u>				4. DATE OF DEATH Month <u>March</u> Day <u>18th</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/27/11</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber helper</u>		11. BIRTHPLACE (State or foreign country) <u>Brunswick, Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>718-09-5501</u>		17. INFORMANT <u>Mrs. Janet Sylvester (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic alcoholism</u> <u>581.1</u> DUE TO <u>Fatty infiltration of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard C. Singlet</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>March 21, 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. Dalba</u>			

MEDICAL CERTIFICATION

STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

MAR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02525

CERTIFICATE OF DEATH

Reg. Dist. No.

02533

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A.H.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>				c. LENGTH OF STAY IN 1b <i>31 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>14304 Sherril</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Eric H</i> Middle <i>Thomas</i> Last				4. DATE OF DEATH Month <i>March</i> Day <i>23</i> Year <i>1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 26 1888</i>	
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Penn State</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>Leage Sparks</i>				14. MOTHER'S MAIDEN NAME <i>Dora Jones</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>William F Thomas Jr</i> Address <i>4304 Sherril St</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>442x Hypertensive Cardio-vascular renal disease</i> DUE TO (b) <i>renal disease</i> DUE TO (c) <i>Generalized arterio-sclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> <i>4 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260x Diabetes Mellitus Duration (3)</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <i>11</i> p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>1/20</i> , 1953, to <i>March 23</i> , 1957, that I last saw the deceased alive on <i>March 23</i> , 1957, and that death occurred at <i>7:25</i> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <i>Harry Deibel</i> M.D. <i>1226 Hanover St.</i>				<i>3/23/57</i>			
PHYSICIAN'S NAME (Type) <i>HARRY DEIBEL, M. D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>March 24 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Gechar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>A.H. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. J. Brown</i> ADDRESS <i>Ex 1410 S Charles St</i>				24. RECORDED BY REGISTRAR <i>MAK 25 1957</i> 25. REGISTRAR'S SIGNATURE <i>Ada Whitson</i>			

1140

BUREAU V. J.

RECEIVED

2483 CERTIFICATE OF DEATH

Reg. Dist. No.

02534
21

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 10 Annapolis		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital			d. STREET ADDRESS Truxton Hgts		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First SELMA Middle TUCKER Last			4. DATE OF DEATH Month March Day 20 Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1874		9. AGE (In years last birthday) yrs. 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Mobile, Alabama		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 418-01-1116F	17. INFORMANT Mrs Lula B. Posey- Daughter- Same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 6 hrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/20 , 19 57 , to 3/20 , 19 57 , that I last saw the deceased alive on 3/20 , 19 57 , and that death occurred at 5:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 90 Cathedral St. Annapolis, Md. DATE SIGNED 3/21/57					
ACTUAL SIGNATURE John R. Hedeman M.D.					
PHYSICIAN'S NAME (Type) John R Hedeman M.D					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		22b. DATE THEREOF 3-24-57		22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	
22d. LOCATION (City, town, or county) (State) Bessemer, Jefferson Co., Alabama		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE John J. French	
25. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 22 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

02526 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02535

Reg. Dist. No.

21

Items 8&17 Film G212 3/19/57 GTE

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bay Ridge		c. LENGTH OF STAY IN 1b 20 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle LEE Last WARD		4. DATE OF DEATH Month March Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 March 13, 1875
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Oxon Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Spencer		14. MOTHER'S MAIDEN NAME Anne Schaaf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO.	
17. INFORMANT H. John W. Joynt, 1401 K St NW, Washington DC		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1957 , to March 13, 1957 , that I last saw the deceased alive on March 7, 1957 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Joynt		DATE SIGNED March 13, 1957	
PHYSICIAN'S NAME (Type) Amey, M.D.		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/16/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph S. Sorenson		24a. REC'D BY REGISTRAR AR 15 1957	
ADDRESS 1756 Pennsylvania Ave NW, Washington, DC		24b. REGISTRAR'S SIGNATURE Wm. J. French	

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
MAY 15 1957		BALTIMORE, MARYLAND		NATURAL	
AGE		SEX		RACE	
60 YEARS		FEMALE		WHITE	
DATE OF BIRTH		PLACE OF BIRTH		MANNER OF BIRTH	
MAY 15 1897		BALTIMORE, MARYLAND		NATURAL	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
MAY 15 1957		BALTIMORE, MARYLAND		NATURAL	
AGE		SEX		RACE	
60 YEARS		FEMALE		WHITE	
DATE OF BIRTH		PLACE OF BIRTH		MANNER OF BIRTH	
MAY 15 1897		BALTIMORE, MARYLAND		NATURAL	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
MAY 15 1957		BALTIMORE, MARYLAND		NATURAL	
AGE		SEX		RACE	
60 YEARS		FEMALE		WHITE	
DATE OF BIRTH		PLACE OF BIRTH		MANNER OF BIRTH	
MAY 15 1897		BALTIMORE, MARYLAND		NATURAL	

BUREAU V. S.

MAR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02527 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02536

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>40 y.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>On pavement in back of home.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert C. Ward</u>				4. DATE OF DEATH Month <u>March</u> Day <u>26th.</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/20/83</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Agent</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.F. Federal & Loan</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas S. Ward</u>	
14. MOTHER'S MAIDEN NAME <u>Mary A. Coulbourn</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>213-22-0269</u>		17. INFORMANT <u>Mrs. Ethel T. Ward, (wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular diseases</u> (a), stating the underlying cause last. (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on the cement walk.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>4.50</u> a. m. <u>3/26/57</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>In the back yard of home. Glen Burnie A.A. Md.</u>	
20f. (City or town) <u>Glen Burnie</u> (County) <u>A.A.</u> (State) <u>Md.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				DATE SIGNED <u>3/28/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn RFD, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				DATE <u>March 28, 1957</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to fading and bleed-through from the reverse side.

RECEIVED
BUREAU V. S.
APR 2 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film Q212 3-22-57 et

CERTIFICATE OF DEATH

0253728

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b Baltimore City 3 Vol-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 631 Portland Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Florence Middle McClelland Last Winters				4. DATE OF DEATH Month 3 Day 1 Year 19 57			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given		9. AGE (In years last birthday) 25? yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Unk.		12. CITIZEN OF WHAT COUNTRY? Unk.	
13. FATHER'S NAME Unk.				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records			
				Crownsville State Hospital Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Degeneration DUE TO (c) Catatonic Schizophrenia							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Crownsville, Md.		(County) (State)	
21. I certify that I attended the deceased from 2/17 , 19 57 , to 3/1 , 19 57 , that I last saw the deceased alive on 3/28 , 19 57 , and that death occurred at 6:40 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Benedict				ADDRESS (Street, city or town, state) Crownsville, Md.			
DATE SIGNED 3/1/57							
PHYSICIAN'S NAME (Type) L. Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/57		22c. NAME OF CEMETERY OR CREMATORY Mount Calvary		22d. LOCATION (City, town, or county) (State) Brooklyn, A.A. Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson				ADDRESS 1000 Brantley Ave.		24a. REC'D BY REGISTRAR DATE 3/8/57	
				24b. REGISTRAR'S SIGNATURE J. M. Joyce			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. S.

MAR 11 1957

RECEIVED

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1805 Robert Small St.</u>		d. STREET ADDRESS <u>1805 Robert Small St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>Watson</u> Last <u>Watson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-56</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>25</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Character</u>		14. MOTHER'S MAIDEN NAME <u>Lorene Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>770</u>	
17. INFORMANT <u>Manuel Turner - Annapolis, Md.</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>492X</u> DUE TO (c) <u>492X</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-25</u> , 19 <u>57</u> , to <u>3-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-25</u> , 19 <u>57</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Faye W. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Cathedral St</u> DATE SIGNED <u>3-26-57</u>	
PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>		<u>62 Cathedral St</u> <u>3-26-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Kesse, Jr - Annapolis, Md.</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. RECEIVED BY REGISTRAR <u>APR 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Funch</u>	

BUREAU V. 5

APR 10 1957

RECEIVED

02529 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNAPOIS</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNIE AFUNDE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD Md</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNIE AFUNDE GENERAL</u>		d. STREET ADDRESS <u>1 FRANKLIN ST</u>	
3. NAME OF DECEASED (Type or print) <u>RACHEL</u> <u>CATHERINE WATTS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/9/1915</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>8</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>ARNOLD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES WOODS</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE HENTSMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>SAMUEL WATTS</u> Address <u>ARNOLD Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>600.0</u> DUE TO <u>Chemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Pyelonephritis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 19, 1957</u> to <u>March 27, 1957</u> , that I last saw the deceased alive on <u>March 27, 1957</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u>		ADDRESS (Street, city or town, state) <u>110 - clay St. Ann Arbor, Mich.</u> DATE SIGNED <u>3/29/57</u>	
PHYSICIAN'S NAME (Type) <u>DR. B. HICKS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/31/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>		22d. LOCATION (City, town, or county) (State) <u>ARNOLD Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur B. Hicks</u> ADDRESS <u>43 Northwest St ANNAPOLIS Md</u>		24a. REC'D BY REGISTRAR <u>ARR 1 1957</u> 24b. REGISTRAR'S SIGNATURE <u>JU - U. Ummch</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		EDUCATION		OCCUPATION		RELIGION		MANNER OF DEATH		CAUSE OF DEATH		IMMEDIATE CAUSE OF DEATH		DISEASE OR INJURY	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERIC		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL		SIGNATURE OF CREMATION		SIGNATURE OF OTHER	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

APR 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02539

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>A. A. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVIERA BEACH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO RIVIERA BEACH</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WANDA ROAD</u>		d. STREET ADDRESS <u>WANDA ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>SYLVIA</u> Middle <u>WEBER</u> Last <u>WEBER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 31, 1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ROBERT GANZ HORN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH MAGINNY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MRS. DORA MAE WILLIAMS</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of sigmoid</u> 153X DUE TO <u>General metastasis to abdominal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>mesenteric and liver -</u> (c) <u>Hyper trophic arthritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hyper trophic arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>1-3</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-3</u> , 19 <u>57</u> , to <u>3-13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-10-57</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>ALL alias M.D.</u>		ADDRESS (Street, city or town, state) <u>477 Fulton Ave. Balt. Md.</u>	
PHYSICIAN'S NAME (Type) <u>A C A I A S</u>		DATE SIGNED <u>3/13/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 16, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond G. Gorce</u>		ADDRESS <u>4001 Ritchie Hwy</u>	
24a. REC'D BY REGISTRAR <u>DATE 3/26/57</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Dralby</u>	

MAR 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02531 CERTIFICATE OF DEATH

02540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A.Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A.Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Severn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 205 Rt. 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ESTHER Middle WEST Last WEST				4. DATE OF DEATH Month March Day 3 Year 1957			
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1888	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Keysville Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sidney Johnson				14. MOTHER'S MAIDEN NAME Annie Bolden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Elizabeth Casey Box 205 Rt. 2 Severn Address Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Acute Cerebral Thrombosis (b) Senility (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Feb 26 - 5 P. to March 3 - 9 P. , that I last saw the deceased alive on March 3 - 9 P. , and that death occurred at 9 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph Lipsky M.D.				DATE SIGNED March 3 - 1957			
PHYSICIAN'S NAME (Type) Joseph Lipsky				ADDRESS Odenton Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate R. Williams				ADDRESS 322 N. Schroeder St.		24a. REC'D BY REGISTRAR 3/6/57	
				24b. REGISTRAR'S SIGNATURE Clara H. Hupp			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2484 CERTIFICATE OF DEATH

Reg. Dist. No.

02541
21

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Annapolis</u>				c. LENGTH OF STAY IN 1b <u>2 Hrs 40 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 3 Vol-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>				d. STREET ADDRESS <u>2000 Crestview Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur</u>		First <u>Jay</u> Middle <u>WHITE</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-15-89</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Arthur WHITE</u>				14. MOTHER'S MAIDEN NAME <u>Florence BOWMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1917-1947</u>		17. INFORMANT <u>USNH RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction, Myocardium</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 March</u> , 19 <u>57</u> , to <u>26 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>26 March</u> , 19 <u>57</u> , and that death occurred at <u>1:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u>							
PHYSICIAN'S NAME (Type) <u>R. K. MOXON, CDR, MC, USN</u>				<u>26 March 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 1, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> Hopping Funeral Home				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. S.

MAR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02532 CERTIFICATE OF DEATH

02542

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Edward J. White</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.G.C. Bd. Education</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas White</u>		14. MOTHER'S MAIDEN NAME <u>Ida White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war and dates of service)		16. SOCIAL SECURITY NO. <u>770</u>	
17. INFORMANT <u>Edith L. White - Edgewater, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Cardiac Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-19-54</u> , 19____, to <u>3-14-57</u> , 19____, that I last saw the deceased alive on <u>3-11-57</u> , 19____, and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>CL</u>		ADDRESS (Street, city or town, state) <u>[Address]</u> DATE SIGNED <u>3-15-57</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-17-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Macedonia</u>		22d. LOCATION (City, town, or county) (State) <u>Danvers Quarter, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		ADDRESS <u>[Address]</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

George Washington
White
7-20-1888
St. Louis
St. Louis
St. Louis

BUREAU V. 3.

MAR 19 1957

RECEIVED

George Washington
White
7-20-1888
St. Louis
St. Louis
St. Louis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02534 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02544

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bay Ridge</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sands Road</u>		e. STREET ADDRESS <u>1 Sands Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Majorie</u> Middle <u>C.</u> Last <u>Wilhelmson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 1923</u>
9. AGE (In years last birthday) <u>33</u> yrs.		10. IF UNDER 1 YEAR Months <u>33</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>"Unk"</u>		14. MOTHER'S MAIDEN NAME <u>"Unk"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Berthel E. Wilhelmson</u>	
17. INFORMANT <u>Berthel E. Wilhelmson</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>976X</u> DUE TO <u>Gun Shot wound Skull</u> <u>Under</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Due to</u> (b) <u>Gun Shot wound Skull</u> <u>Under</u> (c) <u>Gun Shot wound Skull</u> <u>Under</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gun Shot wound Skull</u> <u>Under</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Gun Shot wound Skull</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Gun Shot wound Skull</u>	
20c. TIME OF INJURY Month, Day, Year <u>3 5 1957</u> Hour a.m. <u>3 5</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>APACO 110</u> (County) <u>APACO 110</u> (State) <u>APACO 110</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Ch. L. W. Hardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. L. W. Hardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-8-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) <u>Prince George Co</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Layton</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>3/8/57</u>		24b. REGISTRAR'S SIGNATURE <u>V. V. V. V. V.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

MAR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02533 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bay Ridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bay Ridge</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sands Point Road</u>				d. STREET ADDRESS <u>1 Sands Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Curt</u> Middle <u>Evans</u> Last <u>Wilhelmson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 18, 1956</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Berthil E. Wilhelmson</u>				14. MOTHER'S MAIDEN NAME <u>Majorie Cumming</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Berthil E. Wilhelmson</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound Chest</u> 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3 19 57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. W. Hardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. W. Hardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-8-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3/7/57</u>		24b. REGISTRAR'S SIGNATURE <u>V. D. Daniel</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2046331XV5

NEW YORK AND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's findings.

BUREAU V. 3

MAR 11 1957

RECEIVED

CERTIFICATE OF DEATH

02535

02545 28
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 5yrs. 43days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 2434 Druid Hill Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Joseph Middle Alexander Last Wilson		4. DATE OF DEATH Month 3 Day 7 Year 1957					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/17	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months 3 Days 7 Hours 57 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joseph Wilson				14. MOTHER'S MAIDEN NAME Mary Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records Crownsville State Hosp. Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypostatic Pneumonia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Respiratory failure and cardiac failure secondary to Cerebral Vas-							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form) Car Accident					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/23 , 19 52 , to 3/7 , 19 57 , that I last saw the deceased alive on 3/7 , 19 57 , and that death occurred at 4:45p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Ludwig Benedict				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 3/8/57	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/11/57		22c. NAME OF CEMETERY OR CREMATORY National Cemetery		22d. LOCATION (City, town, or county) (State) Balto	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home Balto Md				24a. REC'D BY REGISTRAR DATE 11 1957		24b. REGISTRAR'S SIGNATURE H. M. Jones	

MAR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02546

Reg. Dist. No. 22

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Same</u> a. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. LENGTH OF STAY IN 1b <u>9 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Severn</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Donaldson Avenue</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leroy Herbert Wolf</u>			4. DATE OF DEATH Month <u>March</u> Day <u>5th</u> Year <u>19 57</u>				
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2 6/17</u>	9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>		11. BIRTHPLACE (State or foreign country) <u>Landsdown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert Wolf</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Donaldson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>418-07-1224</u>		17. INFORMANT <u>Mrs. L.H. Wolf</u> , Address <u>Severn, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage due to fracture of skull caused</u> <u>976 X</u> DUE TO by self inflicted injury with a double barrel Conditions, if any, which gave rise to immediate cause (b) (c) <u>twelve gauge shot gun</u> (o), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental troubles.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted injury with a gun.</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>9.15 A.M.</u> p. m. <u>3/5/57</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Severn A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>3/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hopping and</u>				ADDRESS <u>Irkle, Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 8 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. Seely</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

BUREAU V. S.

MAR 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 62123-19-57 et

02537

CERTIFICATE OF DEATH

02547

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>6yrs.10mo.20day</u> <u>Baltimore City</u> <u>3Vol-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>1803 Walbrook Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>Wright</u> Last <u>Wright</u>		4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/2/78</u> <u>8-2-82</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Wright</u>		14. MOTHER'S MAIDEN NAME <u>Alice Janor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u> <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville State Hosp.</u> <u>Crownsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/17</u> , 19 <u>50</u> , to <u>3/9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/9</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ludwig Benedict</u> M.D.		ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>3/10/57</u>	
PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore City, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holland Funeral Home - 1631 Druid Hill Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 12 1957</u> 24b. REGISTRAR'S SIGNATURE <u>H. M. Jones</u>	

MAR 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2435 Item 9 Film G212 3-13-57 et
CERTIFICATE OF DEATH

02548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rural Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				/ d. STREET ADDRESS <u>Box #112 Rt. #2 Edgewater, Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Denton</u> Middle <u>Ray</u> Last <u>ZEPP</u>				4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1957</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>17 May 1894</u>		9. AGE (In years lost birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN RET</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Windsor Md.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1912-1928</u>		17. INFORMANT <u>U.S. Naval Hospital, Records</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis Coronary Artery left, anterior descending, branch of.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <u>3-6</u> , 19 <u>57</u> , to <u>3-6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-6-57</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> a. m. from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>3-6-57</u>					
PHYSICIAN'S NAME (Type) <u>R. K. MOXON CDR MC USN</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>		22d. LOCATION (City, town, or county) (State) <u>Tracy Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				ADDRESS <u>Son Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>3/7/57</u>			
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

BUREAU V. S.

MAR 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02538 CERTIFICATE OF DEATH

02549

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anna Arundell County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundell	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 801 Camp Mead Road		d. STREET ADDRESS 801 Camp Mead Road /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lillian (Kmiecik) Ziemba		4. DATE OF DEATH Month March Day 14 Year 1957 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep. 14 1906
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aleksander Chojnowski		14. MOTHER'S MAIDEN NAME Josephine Walczuk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Anna Pilachowski Aunt		Address 240 North Milton Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma of uterus 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 1956, to March 14 , 1957, that I last saw the deceased alive on March 8, 1957 , and that death occurred at 3 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 106 W. Popple Rd Linthicum Md DATE SIGNED 3/15/57 ACTUAL SIGNATURE C. Milton Linthicum PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 18 1957	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.		22d. LOCATION (City, town, or county) (State) German Hill Road County Balto.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Weber		ADDRESS 401 S. Chester Street	
24a. REC'D BY REGISTRAR DATE MAR 15 57		24b. REGISTRAR'S SIGNATURE W. F. Leach	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

See Official

<p>1. Name of deceased: JOHN M. WEBER</p>		<p>2. Date of death: APRIL 18, 1957</p>	
<p>3. Place of death: HOME</p>		<p>4. Cause of death: HEART DISEASE</p>	
<p>5. Age: 65</p>		<p>6. Sex: MALE</p>	
<p>7. Race: WHITE</p>		<p>8. Religion: CATHOLIC</p>	
<p>9. Marital status: MARRIED</p>		<p>10. Occupation: ENGINEER</p>	
<p>11. Date of birth: APRIL 18, 1892</p>		<p>12. Place of birth: BALTIMORE, MARYLAND</p>	
<p>13. Name of informant: JOHN M. WEBER</p>		<p>14. Address of informant: 1234 MAIN ST., BALTIMORE, MD.</p>	
<p>15. Signature of informant: <i>[Signature]</i></p>		<p>16. Date of completion: APRIL 18, 1957</p>	

BUREAU V. 2

MAR 18 1957

RECEIVED